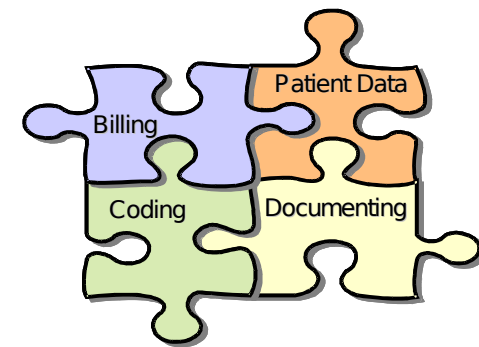


2005 UBU/UBO Conference

UBU Basic (Track 1)

Wednesday - May 18



- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Modifiers (Hughes, Robin)

MHS Coding Guidance (Sheets, Donna)

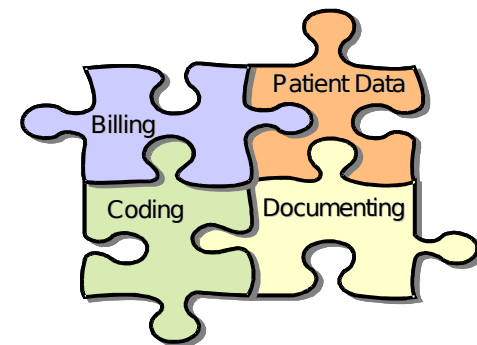
Anesthesia Coding - MTF Version (Millican, Lesvia)

MEPRS 101 (Baker, Jerry)

**FAP/ADAPT/BHOP - Mental Health Programs
(Beauchamp, Laurie)**

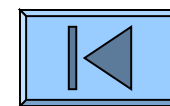
**External Cause of Injuries and E - Codes (Sharpley,
LaNiece)**

**Coding and Workload Integration Committee (Pat Wes
ley, Lt Col Jeanne Yoder, Lt Col Steve Toney)**

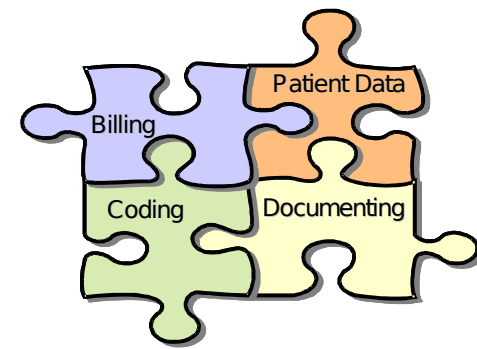


Modifiers

May 18, 2005
Presented by
Robin Hughes-Harris

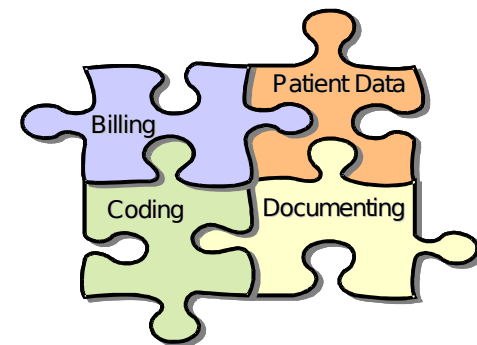


Modifiers



- Modifiers are two digit codes that are attached to an EM service or a procedure code.
- These codes inform the insurance carrier or that this code has been altered in some form or fashion..
- The addition of these codes can increase or decrease the reimbursement.

Modifiers

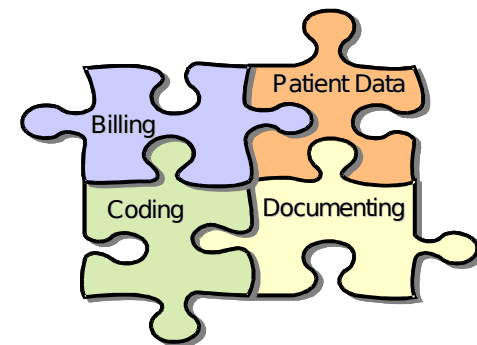


There are some modifiers that are only appended to the EM code and some that are only applicable to the CPT code.

Modifiers that are only applicable to the E&M codes are as follows:

- 21 - Prolonged Evaluation and Management
- 25 - Separate and Identifiable
- 27 - Multiple outpatient Hospital E&M Encounters
- 57 - Decision for surgery

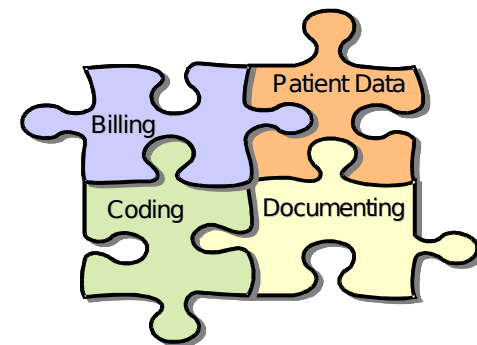
Modifiers that are use of E&M Services only



21-Prolonged Evaluation and Management

When the face-to-face-time or/floor unit service is prolonged or otherwise greater than the usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the EM code. (When this modifier is used a report will be required).

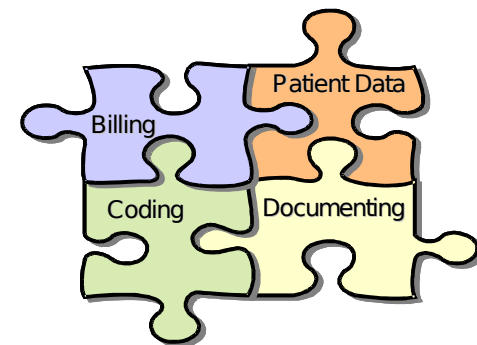
Modifiers



25-Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or service.

- This is a very controversial modifier and is monitored very closely by payors as well as the OIG.

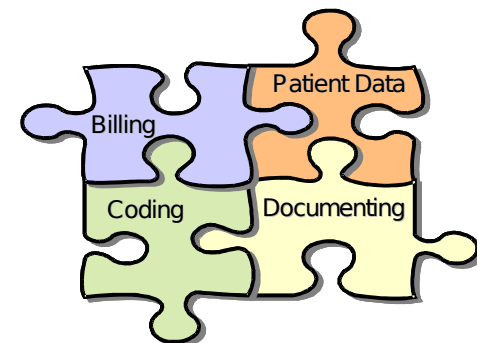
Modifiers



27-Multiple Outpatient Hospital EM Encounters on the same day.

- This modifier is used for hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same day may be reported by adding modifier 27 to each appropriate level outpatient/and or emergency department E/M code (s).
- This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s)
- This modifier is not to be used for physician reporting of multiple E/M services performed on the same date.

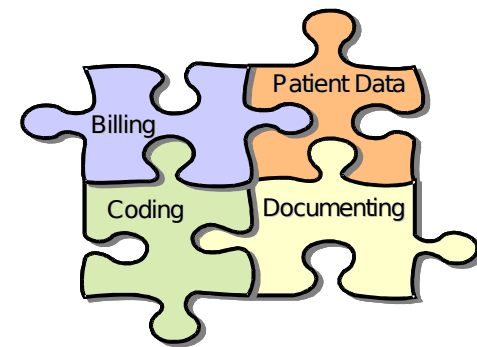
Modifiers



57-Decision for surgery

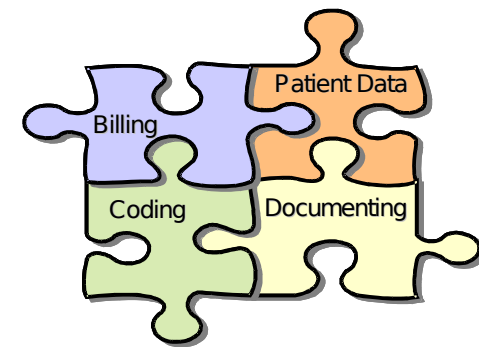
- An Evaluation and Management service that resulted in the initial decision to perform surgery.
- This modifier creates unbundling of services that would not be normally billed and reimbursed in the same day.

Modifiers That Are Appended to CPT Code



- The modifiers that are applicable to the CPT code are as follows:
- 22-Unusual Procedure Services:
- This modifier is used when the service that was provided was greater than that usually required for the listed procedure.

Modifiers That Are Appended to CPT Code



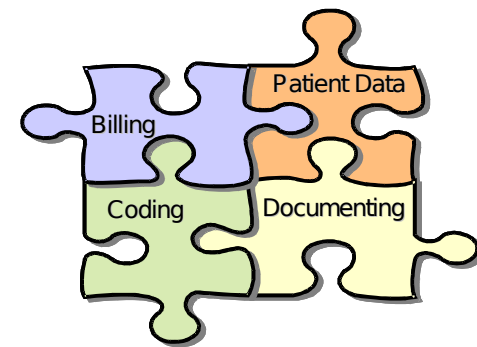
23-Unusual Anesthesia

- Occasionally, a procedure. Which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code for the basic service.

26- Professional Component

- Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.

Modifiers That Are Appended to CPT Code

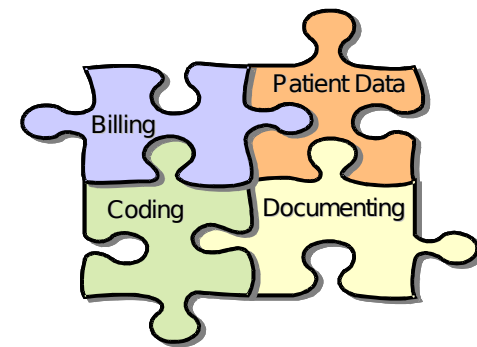


50-Bilateral Procedure

- Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be reported by adding the modifier 50 to the appropriate procedure code.
- Please contact payors for guidelines for submission of claims.

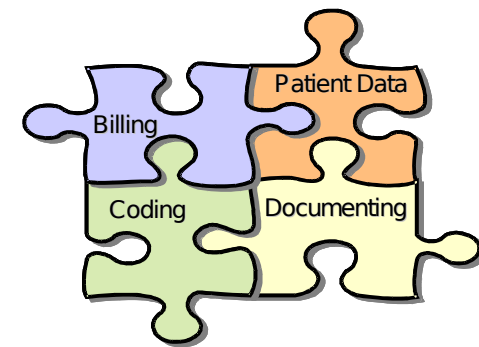
53-Discontinued Procedure

Modifiers That Are Appended to CPT Code



- This modifier is used when the physician may elect to terminate a diagnostic or surgical procedure.
- This termination is due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that the diagnostic or surgical procedure was started but discontinued.
- This modifier is not use to report an elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

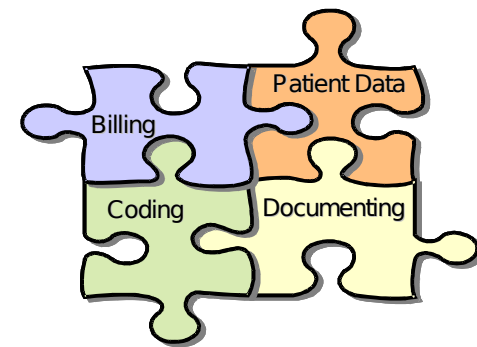
Modifiers That Are Appended to CPT Code



59-Distinct Procedure Service

- Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services that were performed on the same day.
- Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. Examples:
 - A different procedure or surgery
 - A different incision/excision
 - A separate lesion

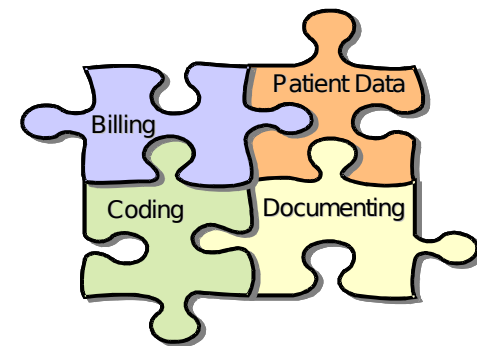
Modifiers That Are Appended to CPT Code



76-Repeat procedure by the same physician:

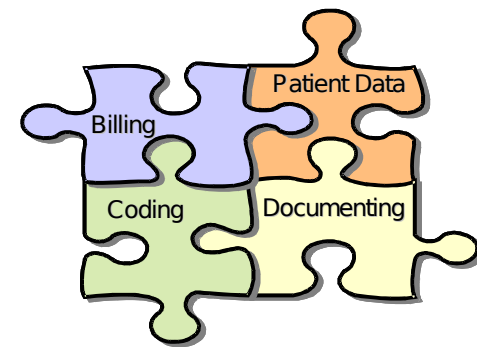
- The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier 76 to the repeated procedure code.

HCPCS Modifiers that are Added to the CPT Code



- HCPCS also has modifiers that are used for the coding and the billing process.
- These modifiers are two digit alpha letters.
- These are a few of the HCPCS Modifiers that we use frequently:
 - LT- (Left) - indicates that a procedure was performed on the Left side of the body.
 - RT- (right) - indicates that a procedure was performed on the right side of the body.

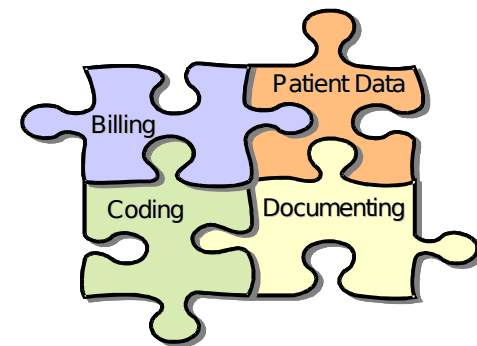
HCPCS Modifiers that are Added to the CPT Code

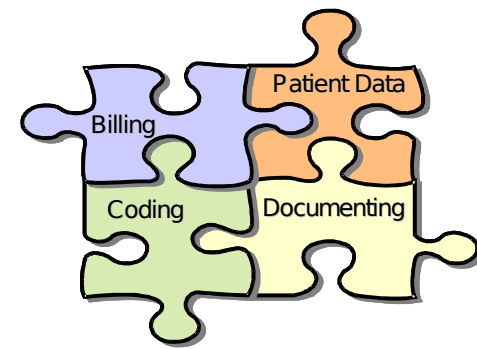


TC- Technical Component

- This modifier is used when the facility owns the equipment and they are charging for the use of their equipment.

Questions???





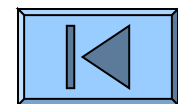
Military Health System (MHS) Coding Guidance

Donna Sheets, RHIA, CCS-P

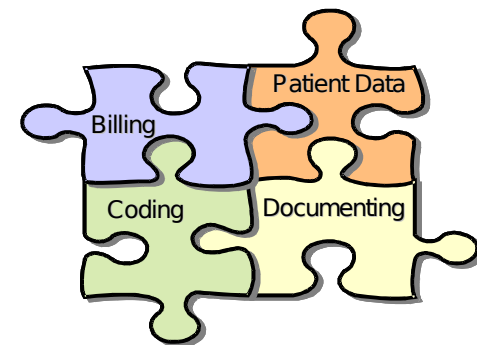
Wednesday, 18 May 2005

Track 1, UBU

0900 - 0950

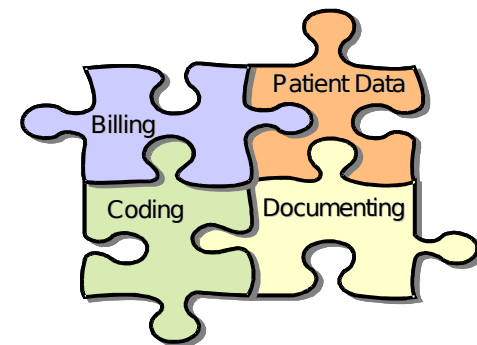


MHS Coding Guidance Objectives



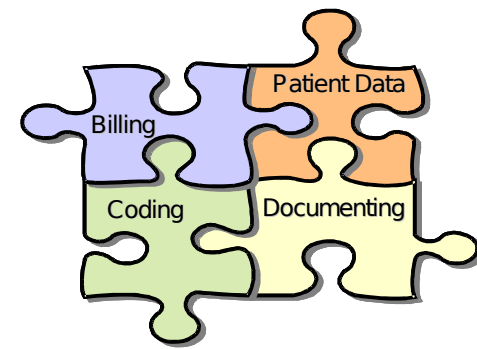
- Understand the Purpose MHS Coding Guidance.
- Review the changes in the MHS Coding Guidance.
- Understand the process for submitting a change for the MHS Coding Guidance.

MHS Coding Guidance Purpose



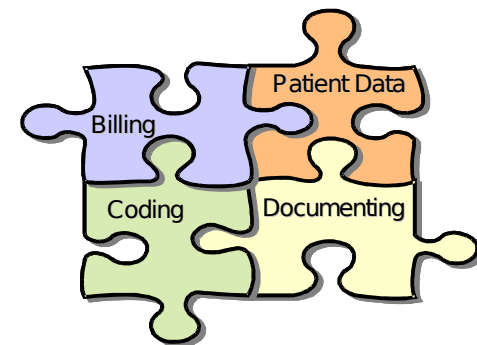
- Provide coding guidance for **PROFESSIONAL** services coding:
 - Outpatient clinic encounters,
 - Emergency Department encounters,
 - Ambulatory Procedure Visits (APV), and
 - Inpatient professional service encounters (Rounds.)
- A supplement to industry standard guidance.

MHS Coding Guidance Purpose



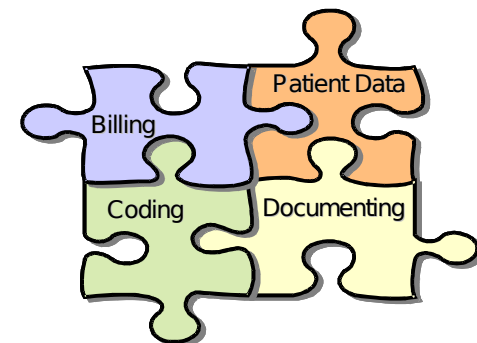
- A comprehensive resource for medical providers, coders, auditors and billing personnel in the MTF.
- A tri-Service document to compile answers to the most common coding questions received at each Service coding helpdesk.
- Easily accessible resource to reference when auditors train and advise medical providers.

MHS Coding Guidance Purpose



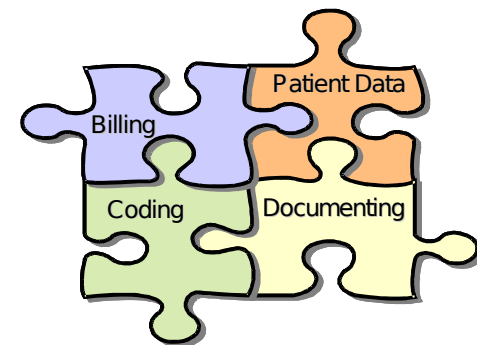
- Explain the idiosyncrasies of MHS coding.
 - We do not strictly follow Center for Medicare and Medicaid Services (CMS) Guidance
 - Evaluation and Management Documentation Guidance
 - DoD Diagnosis Extender Codes.
 - Used for specific population health studies.
 - We use CPT codes to determine workload.
 - The VA Health System does, too.
 - We don't have a Chargemaster.
 - The VA Health System doesn't either.

MHS Coding Guidance Purpose

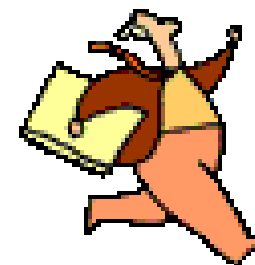


- Provide Examples specific to MHS population.
 - Readiness: PHA, Flight Status, etc...
 - Obstetrics: no use of global OB codes
- Explain MEPRS information for good measure.
 - Ensure resources utilized (costs) are allocated to the appropriate cost (revenue) center.

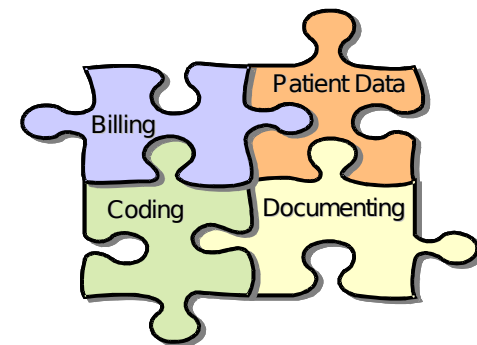
MHS Coding Guidance Changes



- **Who Moved My DoD Extender Codes?**



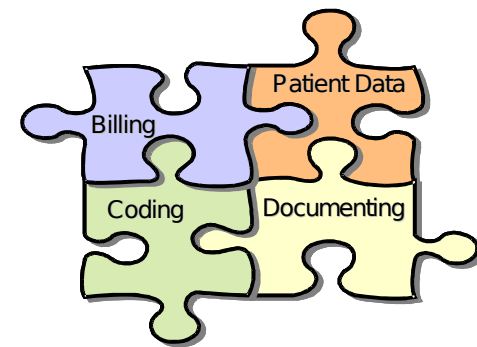
MHS Coding Guidance Changes



- The December 22, 2003 version has 51 pages.
 - Appendix B, DoD Extended Diagnosis Codes, 20 of the 51 pages.
- The April 1, 2005 version is 175 pages.
 - The list of extended diagnosis codes is a separate document posted on the [UBU Website](#).
- **What changed?**

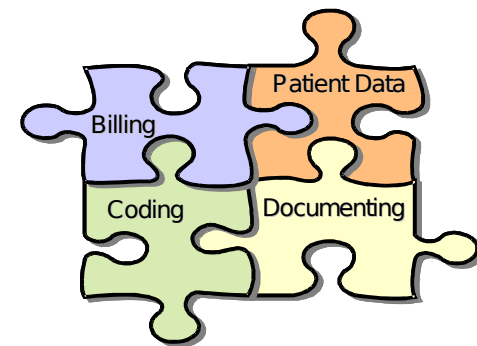
MHS Coding Guidance Changes

Title



- *Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines*
- Previous Title: *Professional Services and **Outpatient** Coding Guidelines*

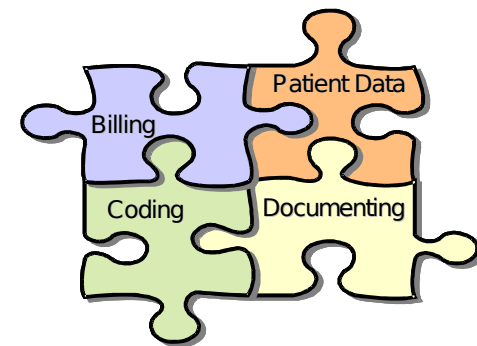
MHS Coding Guidance Changes Overall



- Sections added;
 - Section 4 – Consultations,
 - Section 6 – Specialty Coding,
 - Section 9 - Professional Coding for Inpatient Encounters.
- Section name change.
 - Other Functional Issues Related to **CHCS/CHCSII** or Clinical Scenarios.
- More reference tables.

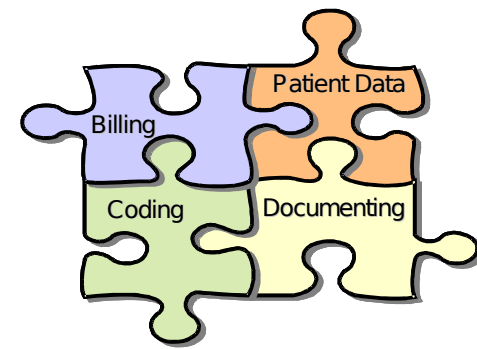
MHS Coding Guidance Changes

Chapter 1 Overview



- Sections Added
 - Coding Reviews/Audits,
 - HIPAA, and
 - Use of the term “SADR.”

MHS Coding Guidance Changes

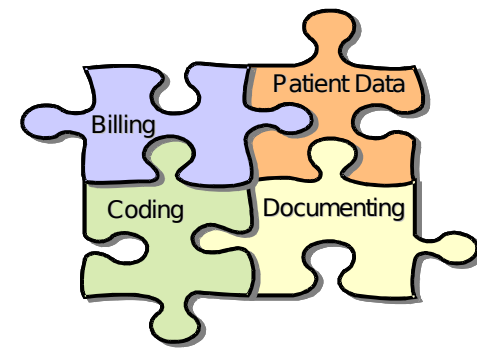


CPT and HCPCS Level II

- Explicit instruction for use of HCPCS Level I (CPT) and Level II codes.
 - CPT codes supercede Level II codes when the verbiage is identical.
 - Level II codes should be used when they **more accurately describe** the service provided.

MHS Coding Guidance Changes

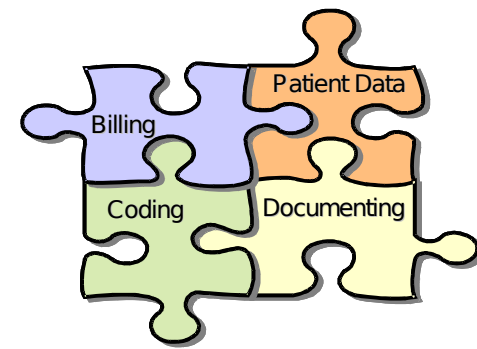
CPT and HCPCS Level II



- Equipment and durable supplies are coded ***only*** when the patient is not expected to return the equipment or supply when it is no longer needed.

MHS Coding Guidance Changes

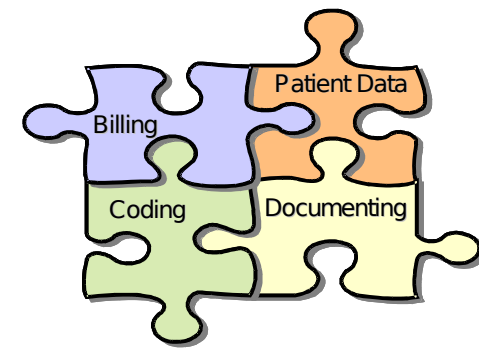
CPT and HCPCS Level II



- Injectables, other pharmaceuticals, and pass-through items (C codes) are ***only coded when they are purchased directly with clinic funds.***
- Inpatient ward stock is not coded.
 - These items are included in the DRG.

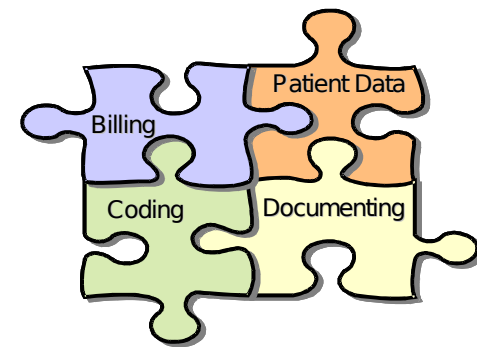
MHS Coding Guidance Changes

Coding Reviews and Audits



- 1.6 Legal Reference
 - The paper medical record is the legal record of care. When there is a difference between what is coded in the ADM and what is documented in the medical record, **a coder may change a code to more accurately reflect the documentation.** When this occurs, **the coder must notify the provider.** The provider is ultimately responsible for the coding.

MHS Coding Guidance Changes

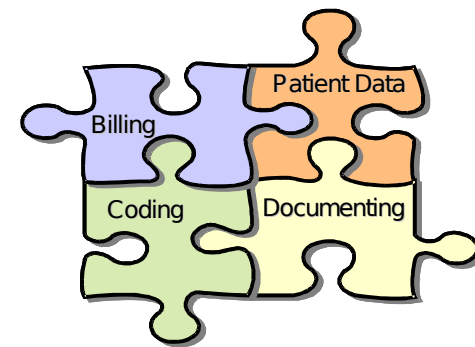


Coding Reviews and Audits

- Facilities will use the audit criteria forms or Service provided forms.
 - [UBU Website](#)
- When errors are identified, they should be corrected.

MHS Coding Guidance Changes

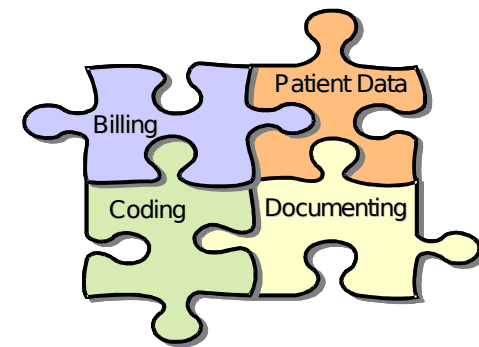
Chapter 2 - Diagnostic Coding



- DoD Extended Diagnosis Codes.
 - No longer an appendix of the Coding Guidance.
 - The root code of an Extender Code is not valid.
- DoD Extended V Code (p. 2-7)
 - Specify type of health exam for active duty and individuals supporting DoD.

MHS Coding Guidance Changes

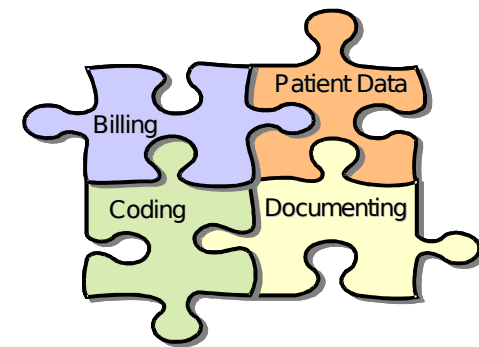
Chapter 2 - Diagnostic Coding



- External Cause of Injury – E Codes
 - If the patient was treated at a local civilian Emergency Department and received follow up/after care at the MTF, the first encounter at the MTF should have an E code.
 - Missing E codes are a common audit finding.

MHS Coding Guidance Changes

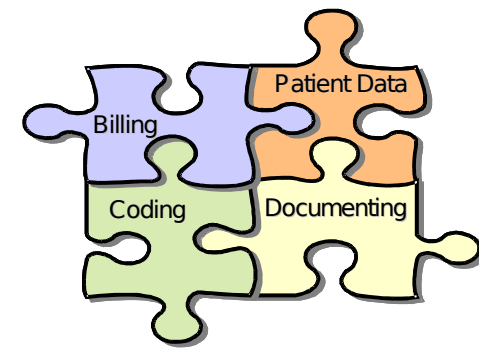
Chapter 2 - Diagnostic Coding



- **2.2.13. Closing-Out an Encounter Due to the Lack of Documentation**
- When there is an indicator that an encounter occurred (e.g., documented technician screening, a prescription/laboratory test/radiology study associated with the encounter), but the provider's record/document of encounter is not available, code the encounter with V68.89 Unspecified administrative purpose, and a 99499 Unlisted E&M.

MHS Coding Guidance Changes

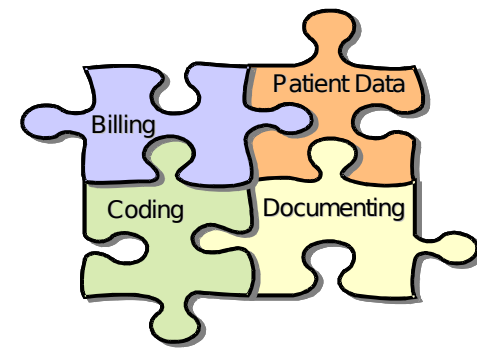
Chapter 3 – Evaluation and Management Coding



- ***Caution:*** *CHCS II/P-GUI Users – The use of the auto negative function certifies that you performed the data gathering indicated in the subjective objective module.*

MHS Coding Guidance Changes

Chapter 3 – Evaluation and Management Coding

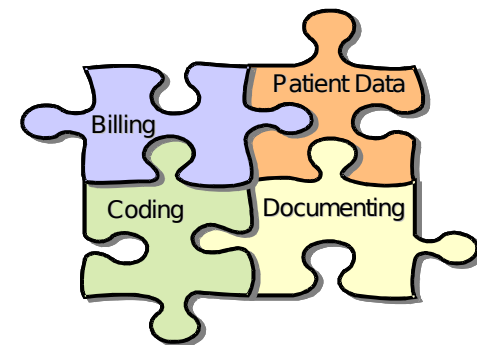


3.6. Telephone Calls 99371-99373

- *Interaction between a privileged provider and a patient.*
- *The documentation must contain evidence of medical decision making by a licensed provider who is directly responsible for the management of care for the patient.*
- ***Telephone calls will not be coded for provider-provider coordination, leaving messages on answering machines or speaking with a Commander regarding an Active Duty member.***
- *Administrative services (e.g. scheduling, billing and communication of non-clinical information) should not be coded.*
- *Privileged providers, including residents beyond post graduate year one (PGY1), may choose from the three E&M codes for telephone calls. (i.e., 99371, 99372, and 99373.)*

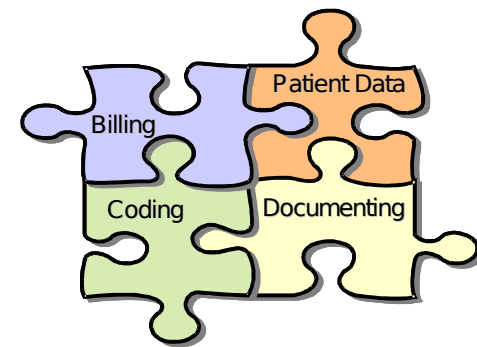
MHS Coding Guidance Changes

Chapter 4 – Consultation



- New Chapter to clarify the differences between a consult and a referral.
 - Consult – evaluate, render an opinion, return opinion and patient to requesting provider.
 - Appropriate level office or inpatient consult codes
 - Referral – evaluate and treat for specific problem.
 - Appropriate level office visit or inpatient E&M code.
 - Use of the SF 513 Consultation does not in and of itself constitute a consultation service. Referrals are frequently made using the SF 513.

MHS Coding Guidance Changes

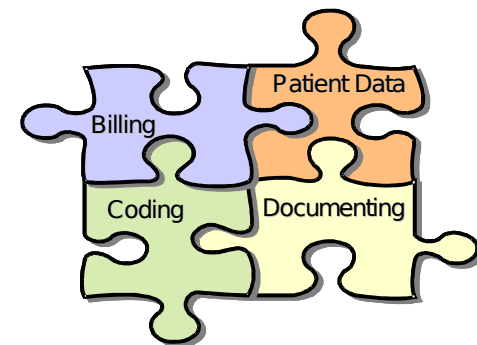


Chapter 5 – Procedural Coding

- Modifiers
 - Complete listing of modifiers that are and are not available for use in the MHS computer system.
 - Modifiers will be listed in this order:
 - Those modifying service (e.g. 26, 50, 54)
 - Type of provider (QX, SA, SB,)
 - Anatomical location (E2, FA, T1).
 - It is very common to find modifiers missing.

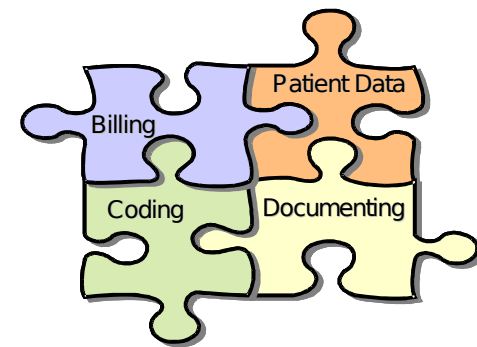
MHS Coding Guidance Changes

Chapter 6 – Specialty Coding



- Anesthesia
- DoD Rule
 - Anesthesia will be reported when the service is provided by a provider other than the surgeon using the anesthesia procedure CPT codes 00100 – 01999 in the B**5 MEPRS.
 - The anesthesiologist or CRNA will be listed as an additional provider on the surgeon's ADM record.
 - Both the surgeon and the anesthesiologist will earn full RVU credit for the procedure (s) performed.

MHS Coding Guidance Changes

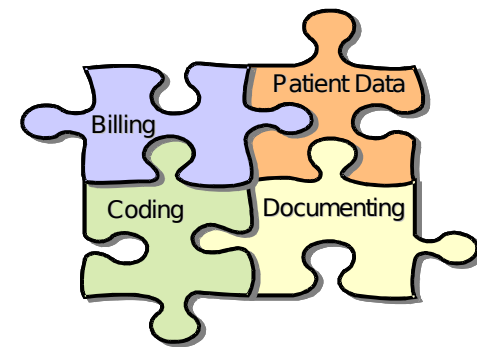


Chapter 6 – Specialty Coding

- Audiology
 - Deployment related encounters will be coded with the V70.5 _ X
 - Hearing Conservation Program (HCP) services will be coded in F MEPRS – Special Program service.
 - A table lists appropriate coding for different HCP encounters (p 6-12).
 - It is very important to list the E codes for cause of hearing loss.
 - Early Hearing Detection and Intervention (EHDI)
 - A table lists appropriate coding for conditions found during EHDI encounters (p6-14).

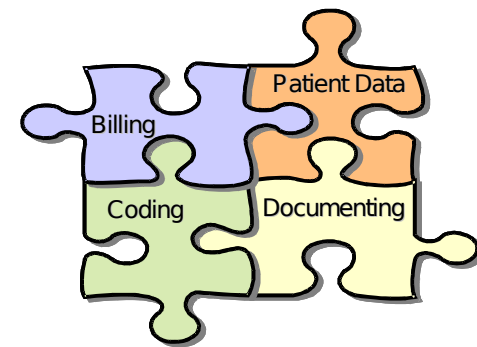
MHS Coding Guidance Changes

Chapter 6 – Specialty Coding



- Chiropractic Services
 - Industry standard guidance.

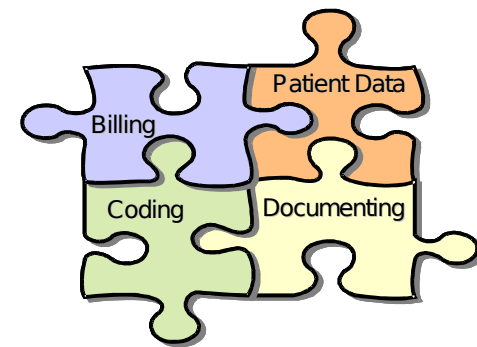
MHS Coding Guidance Changes



Chapter 6 – Specialty Coding

- Dialysis
 - Codes for dialysis include codes for individual encounters and codes for multiple encounters per month.
 - Due to workload accounting, the first of the month will be used to record the appropriate monthly or per day code for services the previous month. All other visits in the month timeframe will use the unlisted dialysis code 90999.
 - E/M – 99499,
 - CPT – 90999, (first visit of month 90922 – 90997)
 - Diagnosis – V56 category.

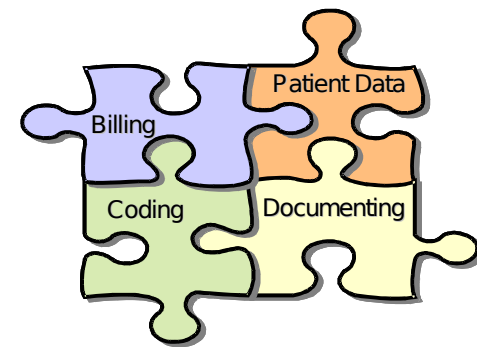
MHS Coding Guidance Changes



Chapter 6 – Specialty Coding

- Flight Medicine Services
 - Annual/periodic flight exams will be reported as comprehensive preventive medicine encounters (99384-99397).
 - Return to Flight Status (RTFS) V68.0
 - **6.5.3.1.** Flight exams will be documented on DD Form 2808 Report of Medical Examination and DD Form 2807-1 Report of Medical History.

MHS Coding Guidance Changes



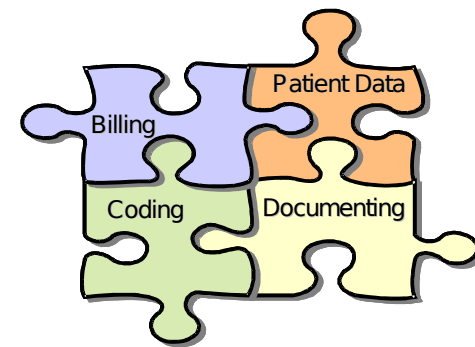
Chapter 6 – Specialty Coding

- Flight Medicine

6.5.2.2. Encounters for initial Flight Medicine

Ground Testing will be coded V70.5 1. The face-to-face follow-up encounter will be coded V68.0 if there are no adverse effects. However, if there are any adverse effects due to the administration of the drugs during the testing, the most severe condition is to be coded as the primary diagnosis and any other adverse effects will be listed as secondary diagnoses. The E code(s) for the identification of the drug(s) causing the adverse effect will also be reported.

MHS Coding Guidance Changes



Chapter 6 – Specialty Coding

- Gynecology



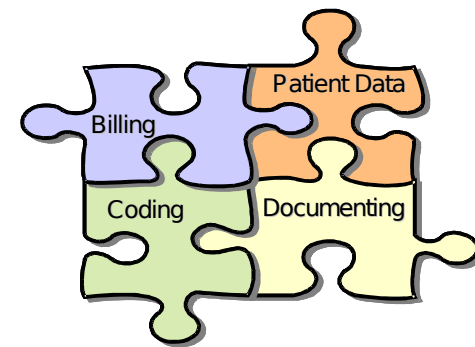
DoD Rule

There is still a requirement to collect a screening Pap smear using Q0091 when one is collected.

The annual well-woman exam will no longer be coded with the preventive medicine E&M, modifier -52 and the G0101.

When a patient receives a breast and pelvic exam only and not enough of the health/preventive requirements to satisfy a physical, the G0101 continues to be the most appropriate code.

MHS Coding Guidance Changes



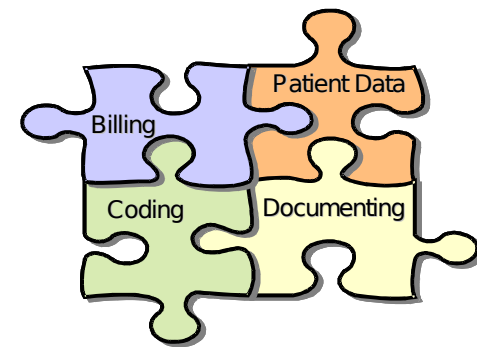
Chapter 6 – Specialty Coding Mental Health



DoD Mental Health Extender Codes

Mental Health Diagnosis Extender codes are a group of ICD-9 codes that have been modified to meet the needs of the Military Services. The extender is paired with a specific ICD code to acquire a unique meaning. Use the appropriate extender for the type of service provided. DOD Mental Health Diagnoses Extender codes can be used in any clinical setting.

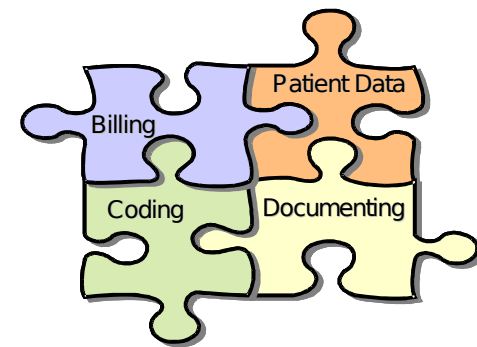
MHS Coding Guidance Changes



Chapter 6 – Specialty Coding

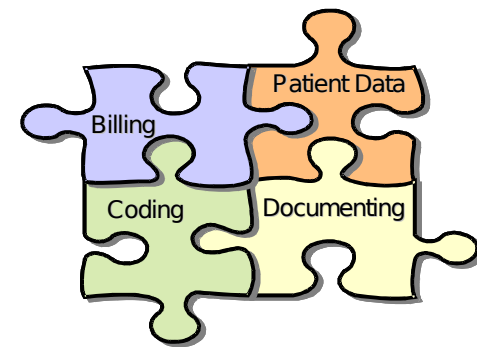
- Nutritional Medicine
 - **6.8.2.2.2. Medical Nutrition Therapy** - Registered Dieticians should use the appropriate medical nutritional therapy code (97802-97804) when conducting nutritional assessments and specific diet training. As these codes are time sensitive, the documentation must reflect the amount of time spent face-to-face with the patient.
 - **6.8.2.3. Non-privileged Providers/Technicians** - All diet technician visits/encounters are coded using 99499 in the E&M field. **Certified Diet Technicians** should use the nutritional medicine codes 97802-97804 for medical nutrition therapy. Diet technicians are authorized to provide instruction on those diets on which they have been certified.

MHS Coding Guidance Changes



- Chapter 6 – Specialty Coding
Obstetrics Services
- Category II CPT obstetric coded 0500F and 0502F, new in CY05 CPT.
- 0500F Initial prenatal care visit.
- 0501F Prenatal flow sheet documented. Do not use as the DoD will use the 0500F Initial prenatal care visit code when the prenatal flow sheet is initiated.
- 0502F Subsequent prenatal visits (continuing care). This code does not include complications or issues not related to the pregnancy.
- Use 59430 (not 0503F) for the uncomplicated postpartum care encounter only. It is usually done between 6 and 8 weeks post partum. Code all other postpartum visits with the appropriate established patient office visit E&M code.

MHS Coding Guidance Changes



Chapter 6 – Specialty Coding

- Occupational Therapy

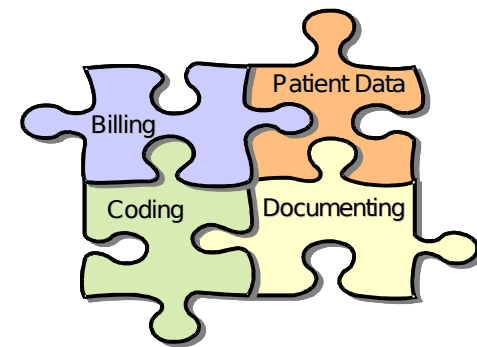


DoD Rule

Occupational therapy encounters for post-deployment therapy sessions will have V70.5_6 as the first listed code and V57.21 as the second listed code. If there is no therapy involved, V70.5_6 is still the first listed code with the patient's physical condition listed second.

MHS Coding Guidance Changes

Chapter 6 – Specialty Coding



- Occupational Therapy and Physical Therapy



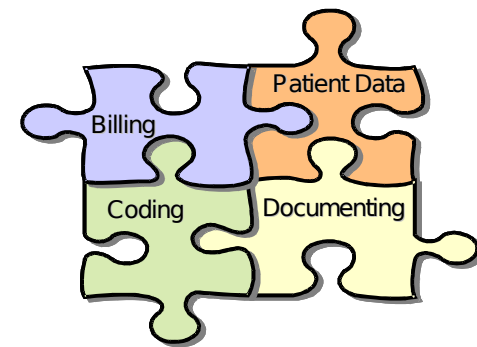
DoD Rule

Inpatient therapy encounters will be reported in ADM. When the screen prompts “Are you from the attending service?” select “NO.” This will create the encounter in ADM.

MHS Coding Guidance Changes

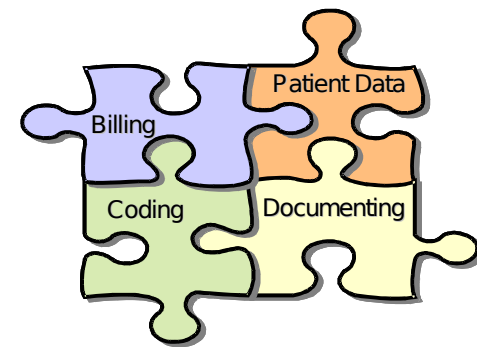
Chapter 6 – Specialty Coding

- Ophthalmology/Optometry



V CODES	DESCRIPTION
V70.5 0	Armed Forces Medical Examination
V70.5 1	Aviation Examination
V70.5 2	Periodic Prevention Examination
V70.5 3	Occupational Examination
V70.5 4	Pre-Deployment Examination
V70.5 5	During Deployment Examination
V70.5 6	Post-Deployment Examination
V70.5 7	Fitness for Duty Examination
V70.5 8	Accession Examination
V70.5 9	Termination Examination

MHS Coding Guidance Changes

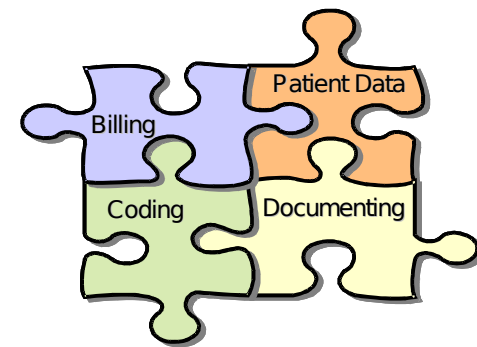


- Chapter 6 – Specialty Coding
Physical Therapy

- **6.12.2.3. Injuries**

- Physical therapy should not be reporting injury diagnoses (ICD-9-CM codes 800-904 and 910-999), which should have been documented in the initial evaluation for the injury. Therefore, physical therapy would report pain or muscle or joint related diagnoses. Physical therapy encounters should not report E codes.
- **6.12.2.1.** All outpatient physical therapy encounters for the purpose of receiving therapy are always coded with the **V57.1** as the first listed diagnosis._
- Exercise counseling (e.g., runner's clinic) is an education V-code of **V65.41**.

MHS Coding Guidance Changes



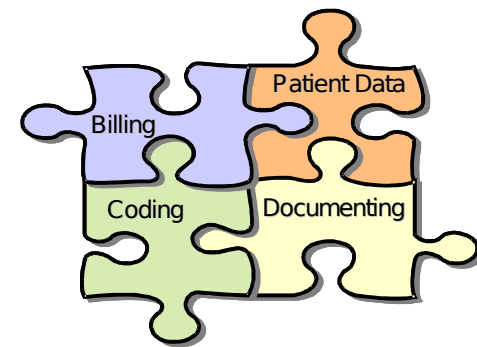
- Chapter 6 – Specialty Coding
Physical Therapy



DoD Rule

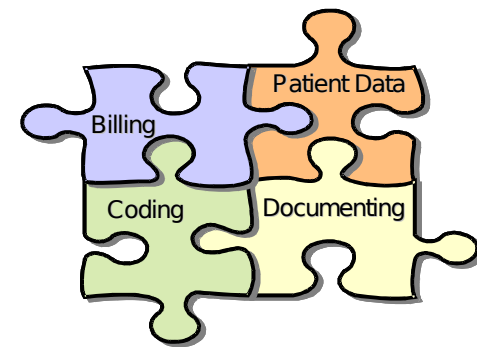
Physical therapy encounters for post-deployment therapy sessions will have V70.5_6 as the first listed code and V57.1 as the second listed code. If there is no therapy involved, V70.5_6 is still the first listed code with the patient's physical condition listed second.

MHS Coding Guidance Changes



- Chapter 6 – Specialty Coding
- Preventive Medicine
- 6.13.1.2.2. Post Deployment Visits
 - At every active duty and family member visit, the provider assesses if the visit is deployment related. All deployment-related visits must have the first listed deployment related code. The deployment related codes are V70.5_._4/5/6.
- Preventive Medicine Counseling
- 6.13.4. Documentation
 - For counseling, the amount of time spent with the patient as well as the time counseling the patient, must be included in the documentation in addition to the date (e.g. 12 Oct 04, 0900-0930, counseling 20 minutes).

MHS Coding Guidance Changes



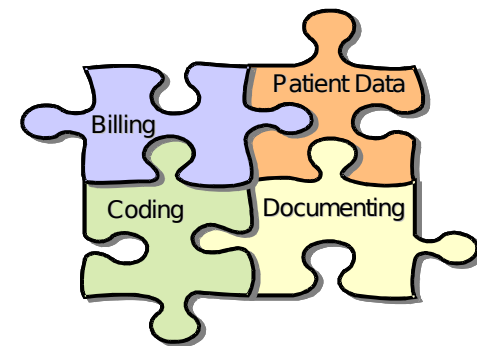
Chapter 6 – Specialty Coding

- Radiation Oncology Services
 - *This section is under review with submissions from the field for other interventional radiation services.*

MHS Coding Guidance Changes

Chapter 6 – Specialty Coding

- Readiness Assessment



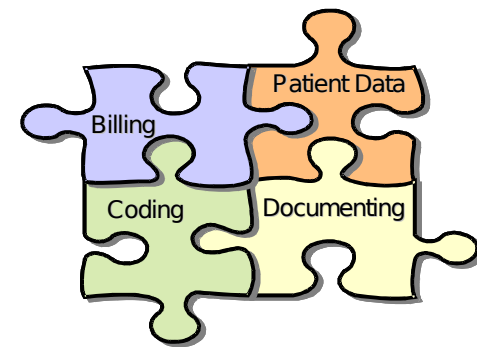
DoD Rule

For Active Duty only, annual preventive health assessment, pre- and post deployment assessment.

If a problem is discovered during a post-deployment visit, use the appropriate problem oriented E&M codes.

For combat related injury use additional diagnosis codes from E990-E999 for “injuries resulting from operations of war.”

MHS Coding Guidance Changes



Chapter 6 – Specialty Coding

- Reconstructive Surgery/Cosmetic Surgery

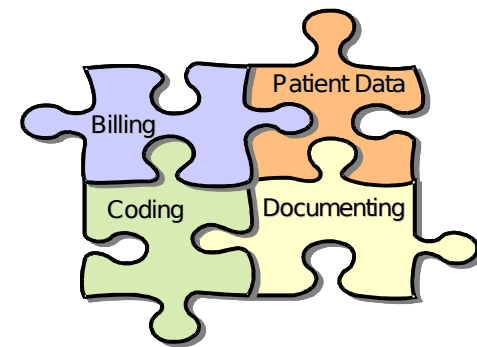


DoD Rule.

Regardless of training or skills maintenance for the provider, the patient must pay for all cosmetic procedures through the Medical Services Accounts (MSA) office and present a paid bill for the services, prior to receiving services.

MHS Coding Guidance Changes

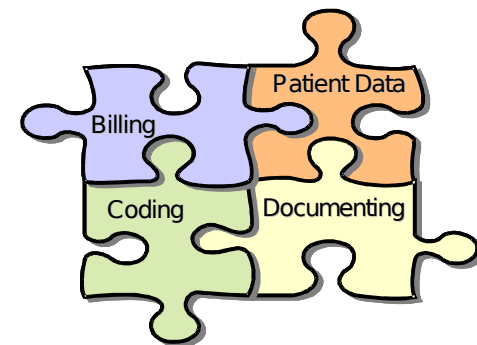
Chapter 6 – Specialty Coding



- Social Work and Family Advocacy Services
 - See chart on page 6-92 for social work coding examples.
 - HCPCS level II modifiers can be used with CPT codes as well as HCPCS level II codes.
 - Common modifiers for social work services are listed on page 6-94

MHS Coding Guidance Changes

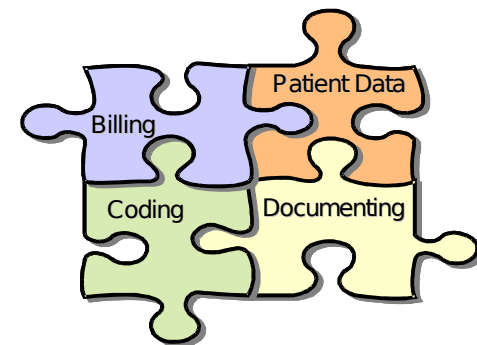
Chapter 6 – Specialty Coding



- Substance Abuse Program Services
 - Some Service specific guidance is listed in this section.
 - Army – Substance Abuse Program (SAP)
 - Navy – Substance Abuse and Rehabilitation Program (SARP)
 - Air Force – Substance Abuse and Rehabilitation Services

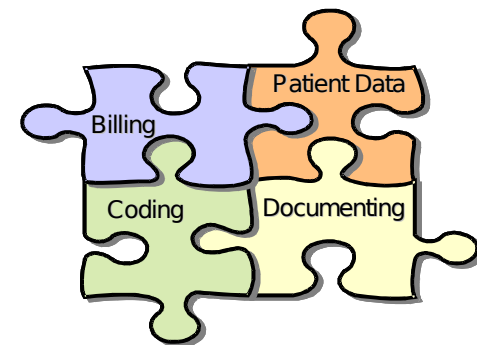
MHS Coding Guidance Changes

Chapter 7 – Ambulatory Procedure Visits (APV)



- Institutional Component of APV
 - 99199
 - Effective 1 October 2004.
 - Only report on lead surgeon's SADR.
 - List last, after all procedures and anesthesia code.

MHS Coding Guidance Changes



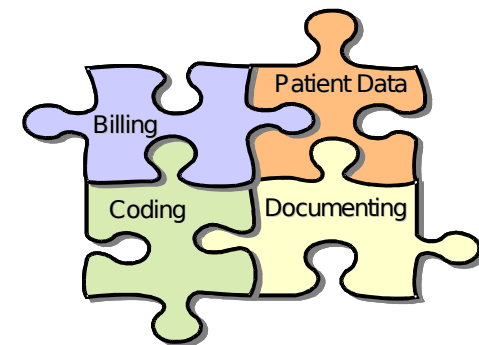
Chapter 7 – Ambulatory

Procedure Visits (APV)

- Canceled APV

- The E&M 99499 will be used for cancelled APVs. In the civilian sector there is no requirement for an E&M, but our computer system currently requires one.
- If a scheduled procedure was started but not completed, then use the appropriate surgical CPT code with appropriate modifier;
- -52 Reduced Services: Service or procedure that is partially reduced or eliminated at the provider's discretion.
- -53 Discontinued Procedure: Use when anesthesia has been started or the patient has been prepped in the operating room suite.
- See Anesthesia section 6.1.13 for coding anesthesia procedures that are cancelled.

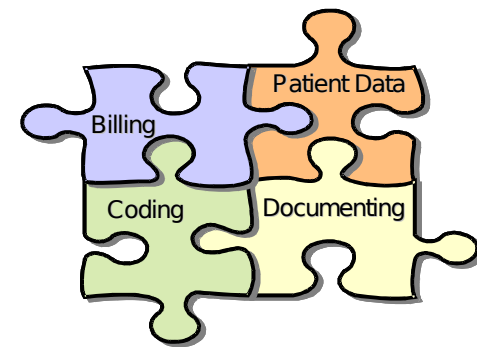
MHS Coding Guidance Changes



Chapter 8 – Other Functional Issues Related to ADM Clinical Scenarios

- 8.1. Use of the “MAIL” Function
- 8.2. For Clinic Use Only, an ADM function
- 8.3. Additional Provider
- 8.4. Telehealth
- 8.5.2.3. Primary Care Exception. For billing purposes, the MHS does not have a primary care exception. For workload credit for both the resident and teaching physician, the DoD will follow CMS documentation guidelines.

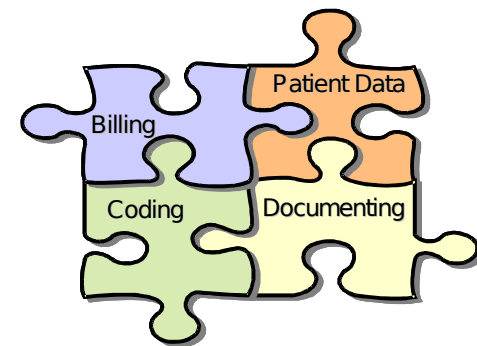
MHS Coding Guidance Changes



Chapter 9 – Professional Coding of Inpatient Encounters

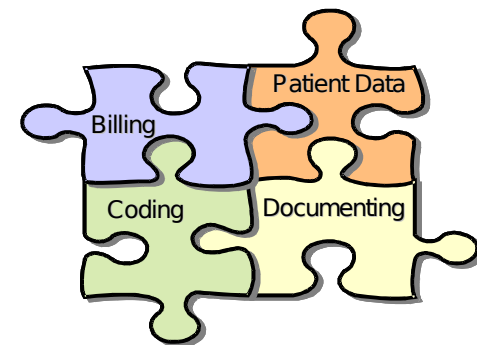
- ***Rounds (RNDS)***
- An appointment type in DoD information systems (CHCS/CHCSII/P-GUI) is designed to capture professional services delivered in the inpatient environment by the service of the attending provider of record.

MHS Coding Guidance Submit a Change



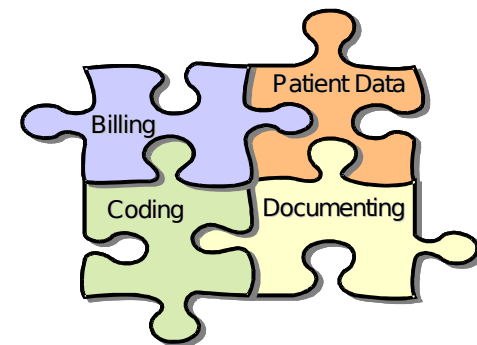
- Each Service staffs a coding helpdesk.
- Army <http://www.pasba.amedd.army.mil>
- Air Force <https://phsohelpdesk.brooks.af.mil>
or 1-800-298-0230
- Navy <https://imcenter.med.navy.mil/045department>

MHS Coding Guidance Submit a Change



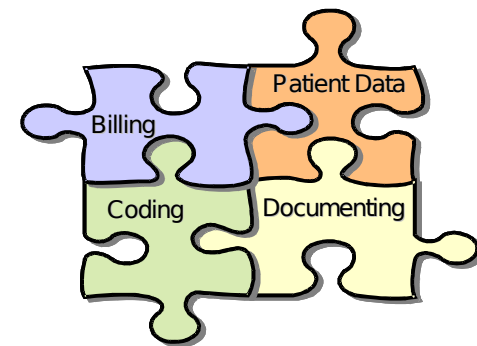
- Quarterly update will be posted on the **UBU Website**.
 - <http://www.tricare.osd.mil/org/pae/ubu/default.htm>
- Future revisions will include highlighted text where changes are made.

Summary

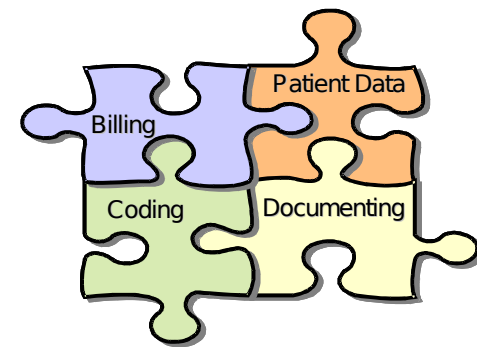


- Understand the Purpose MHS Coding Guidance.
- Review the changes in the MHS Coding Guidance.
- Understand the process for submitting a change for the MHS Coding Guidance.

UBU MHS Coding Guidance



- Questions?

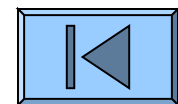


Anesthesia Coding (MTF Version)

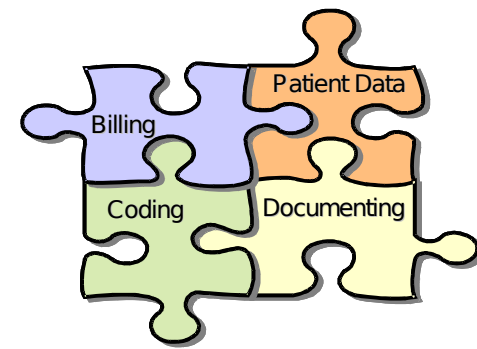
Lesvia O Millican, CPC, PMCC

Wednesday, 18th 2005

Track 1 UBU

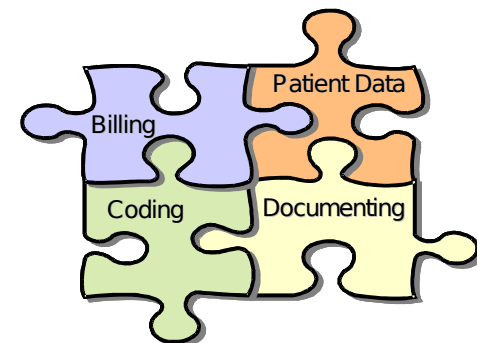


Objectives



- Types of Anesthesia
- Anesthesia coding- Civilian
- MHS Anesthesia coding limitations
- Common coding errors
- Anesthesia codes

Anesthesia Providers



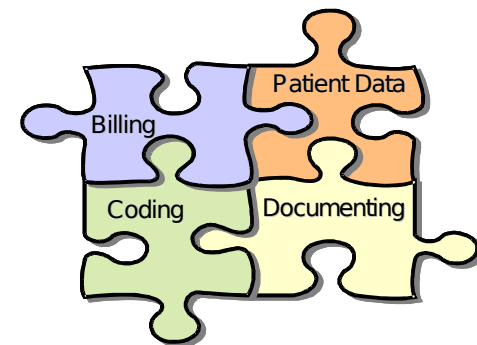
- **Anesthesia service performed personally by anesthesiologist**

- Anesthesiologist codes with AA modifier
- Anesthesiologist performs entire anesthesia service alone- AA modifier
- Anesthesiologist is teaching physician and works with one intern or resident
- Anesthesiologist is continuously involved in a single case involving a student nurse anesthetist

- **CRNA service**

- w/ medical direction by physician -QX modifier
- w/ medical direction by anesthesiologist -QY modifier
- w/ out medical direction by a physician - QZ modifier

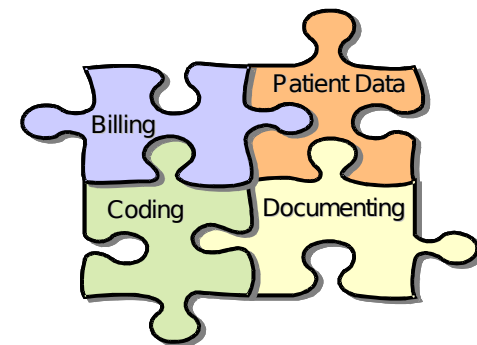
Anesthesia Providers



- **Surgeon who performs procedure**

- Performs procedure and administers anesthesia
 - Will use modifier -47 when available for use in the MHS
- CRNA works under supervision of surgeon.
 - Will use modifier 62

Anesthesia Providers

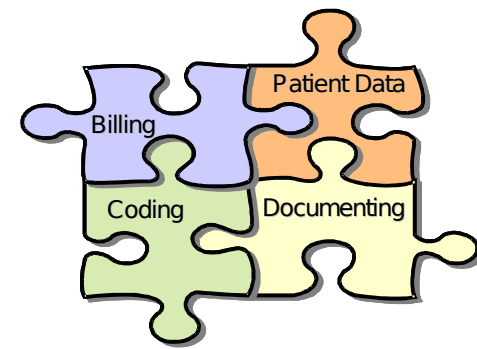


- **Residents under Teaching Physician direction**
- **Anesthesia** -
 - **Teaching anesthesiologist** - Involved in a single procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure, **Code w/ modifier GC**
 - **Teaching physician's physical presence** - Involved during only the preoperative or postoperative visits with the patient is not sufficient. Teaching anesthesiologist - Involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthesiologist, **Code w/ modifier AD** - services as medical direction.
 - **Resident w/out theaching physicina physical presence** **Code w/ modifier GE (only under PC Exception)**

Unified Biostatistical Utility/Uniform

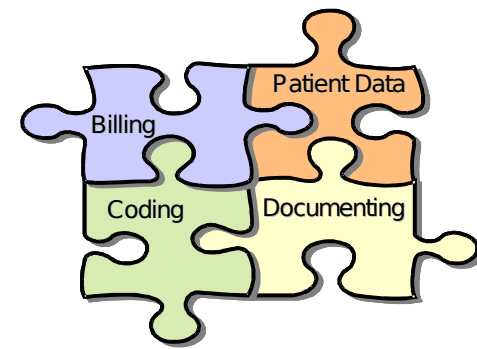
Business Office Conference 2005

Definitions



- **Definitions:**
- **Consciousness** is being clearly aware of yourself and your environment.
- **Unconsciousness** is when you are completely or partially unaware of yourself and your environment, or you don't respond to sensory stimuli.
- **Conscious sedation** is caused when an anesthesiologist administers depressant drugs and/or analgesics in addition to anesthesia during surgery. Consciousness is depressed and you may fall asleep, but are not unconscious.
- **Sleep** is a state of reduced consciousness, depressed metabolism, and little activity of the skeletal muscles. Strong stimuli such as loud noise, bright light or shaking can arouse the sleeper.

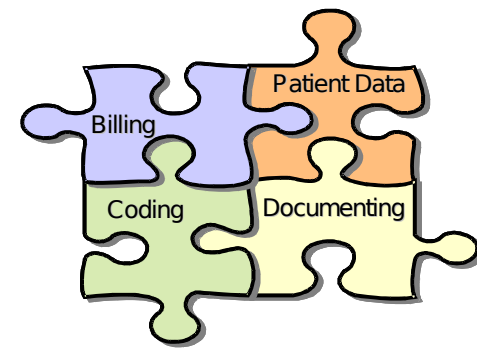
Anesthesia Basics



Anesthesia is divided into four basic categories:

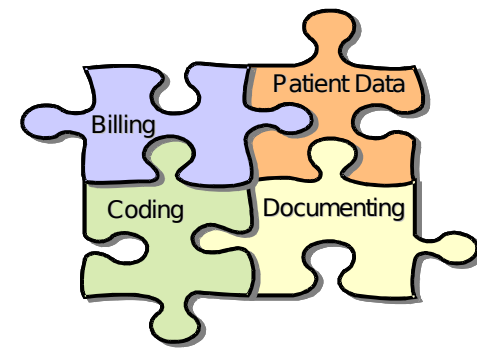
- The Basics
 - General anesthesia
 - Regional anesthesia
 - Local anesthesia
 - Sedation

Effects of anesthesia



- Each type of anesthesia has an effect on a part of the nervous system, which results in a depression or numbing of nerve pathways.
 - General anesthesia affects the brain cells, which causes you to lose consciousness.
 - Regional anesthesia has an effect on a large bundle of nerves to a particular area of the body, which results in losing sensation to that area without affecting your level of consciousness
 - Local anesthesia causes you to lose sensation in a very specific area.
 - Sedation - Some of the drugs that produce general anesthesia in large doses can be used to produce sedation in lower doses and affect brain cells in the same manner

Anesthesia Types cont'd

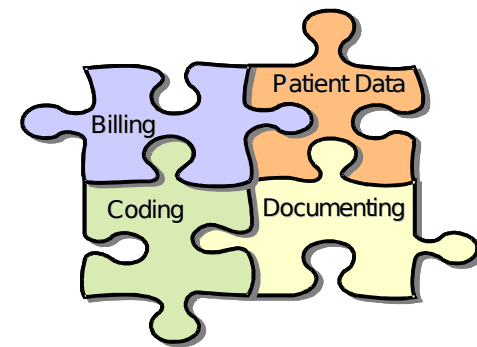


- **Injected Anesthetics**

A liquid anesthetic drug is delivered to the brain by injecting it directly into the bloodstream, usually through an intravenous catheter.

- Examples of injected drugs are **barbiturates**, **propofol**, **ketamine**, and **etomidate**, as well as larger doses of **narcotics** (such as morphine) and **benzodiazepines** (Valium-like drugs).

Anesthesia Types cont'd

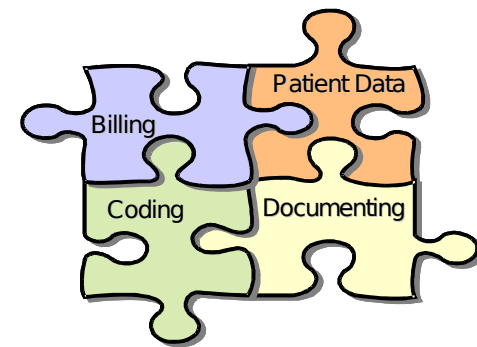


- **Regional Anesthesia**

Regional anesthesia is so named because a "region" of the body is anesthetized without making the person unconscious.

- Example: Spinal anesthesia, which is often used on women during childbirth. A local anesthetic is injected into the spinal fluid and causes a loss of sensation of the lower body. Spinal anesthesia can be used for surgery on the legs or lower abdomen (below the bellybutton).

Anesthesia Types cont'd

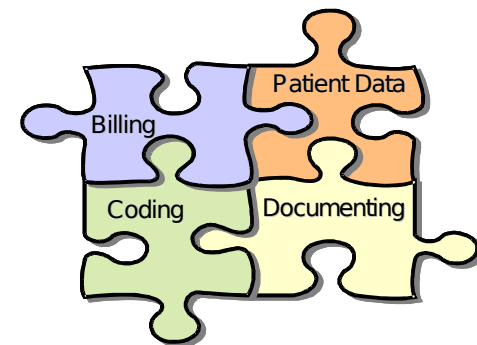


- **Local Anesthesia**

Local anesthesia involves numbing a small area by injecting a local anesthetic under the skin just where an incision is to be made. When used alone, this type of anesthesia has the least number of risks.

- Example: Foreign body removal, a physician will inject lidocaine subcutaneously to numb the local area in which he will be excising the foreign body.

Anesthesia Types cont'd

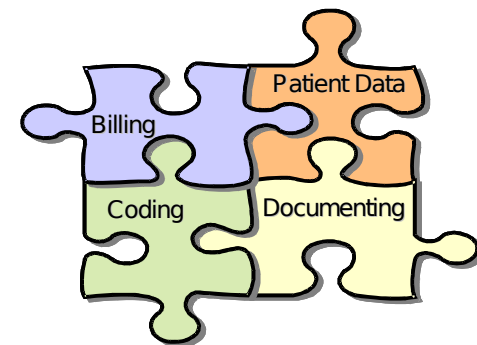


- **Sedation**

Some of the drugs that produce general anesthesia in large doses can be used to produce sedation or "twilight sleep" in lower doses.

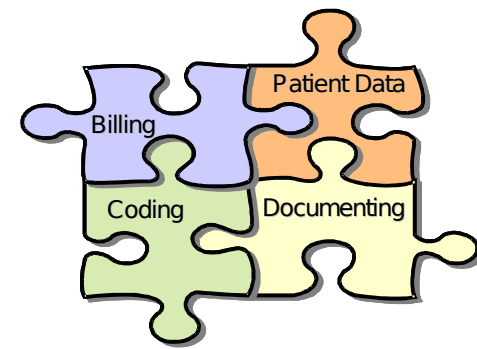
- *Anxiolysis* – light sedation. Nitrous oxide is the most commonly used sedation method to induce this type of relaxation.
- *Conscious sedation* – mild sedation. Nitrous oxide or IV sedation can induce this type of sedation. The patient will be awake and able to respond to commands.
- *Deep sedation* – a state between consciousness and unconsciousness. The patient will not be able to respond to commands in a consistent manner and may need some assistance with breathing in the event they are unable to keep their airway open.

Anesthesia Coding Guides



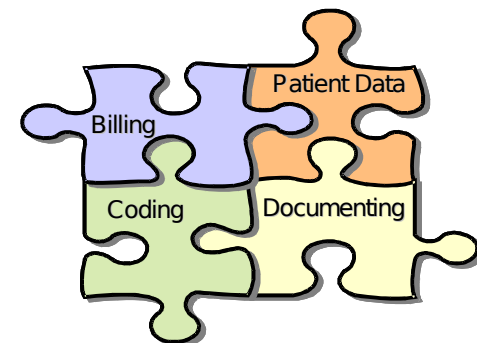
- 2 books, less than \$150, both from the American Society of Anesthesiologists
- 2004 Relative Value Guide, A Guide for Anesthesia Values \$25.00
- 2004 Crosswalk, A Guide for Surgery/Anesthesia CPT Codes \$125.00
- <http://www.asahq.org/index.htm>
- Telephone: 847-825-5586

Civilian Coding



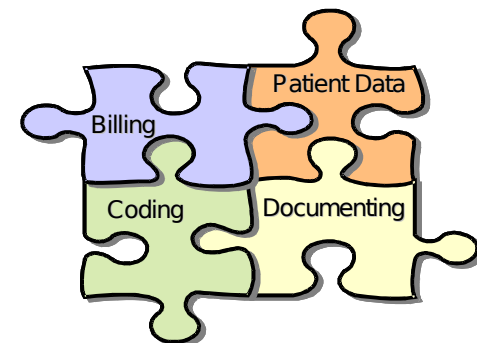
- Identify anesthesia procedure/service
- Assign physical status modifier
- Assign qualifying circumstances (if applicable)
- Assign modifiers (if applicable)
- Calculate anesthesia time/units

MTF Constraints



- Identify anesthesia procedure/service
 - We're ok here
- Assign physical status modifier
 - NOT!
- Assign qualifying circumstances (if applicable)
 - One more for the MHS system!
- Assign modifiers (if applicable)
 - NOT!
- Calculate anesthesia time/units
 - NOT!

MTF Constraints



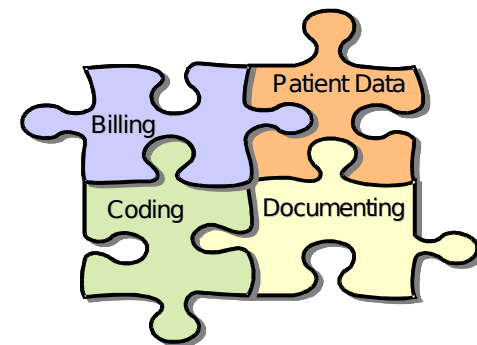
- **Review MHS Systems limitations**

- Cannot currently code units of anesthesia
- Cannot currently code patient status (P1, P2...)
- Cannot currently code appropriate modifier for anesthesiologist, CRNA...(AA, AD,)
- **Cannot enter CPT or any other code more than one time**

Note:

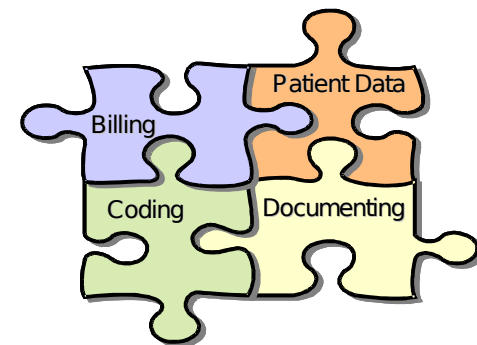
Anesthesia billed and paid as a flat rate

MTF Constraints



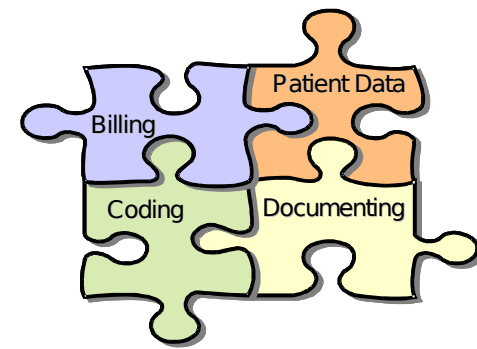
- **The Anesthesiology Coding Need**
- Well trained anesthesiology coding experts are difficult to find.
- Few anesthesiology coding and pain management coding personnel are Certified, a symbol of quality coding.
- Shortage of coders with extensive anesthesiology coding experience.
- Anesthesiology coding is complex and the regulations change frequently, making coding compliance difficult.
- Anesthesiology coder turnover creates peaks and valleys

AF MTF Specific



- There will be two or three Standard Ambulatory Data Reports (SADRs) when an individual other than the surgeon does the anesthesia
 - 1 - In the MEPRS Bxx5 or Bxx7 (for Ambulatory Procedure Visit - APV) or Axxx (for inpatient) surgeon and assistant at surgery
 - 1 - In the MEPRS DFAA for the anesthesiologist doing medical direction or supervision
 - 1 - In the MEPRS DFAA for the anesthesiologist (AA modifier) or for the certified registered nurse anesthetist (CRNA)
- **Note:** Services may differ on where to capture anesthesiologist workload. Follow service directions

DoD Anesthesia Coding Rules

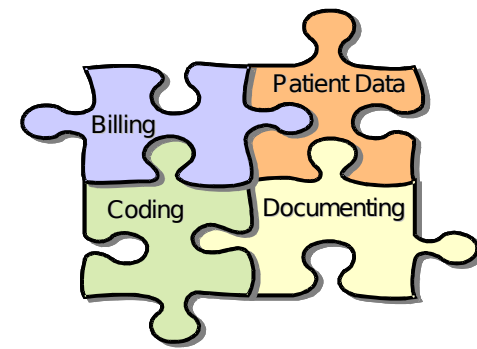


- Inpatient
 - Currently captured with the inpatient bill
 - Do Not Capture Separately

Note: UBO Functional Business Rules

State that Anesthesia performed in conjunction with an inpatient stay will be supported in the inpatient bill.

DoD Anesthesia Coding Rules



- Ambulatory Visits (APV'S)

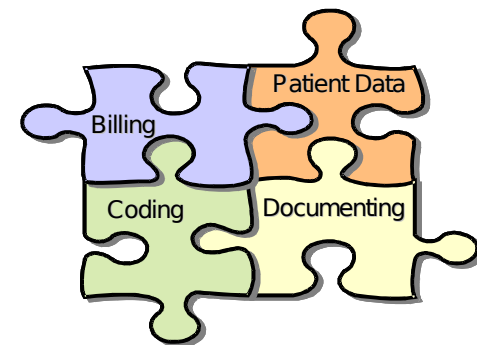
DoD Rule:

Anesthesia services will be reported in DoD MTF's when performed by a provider other than the surgeon.

- Anesthesiologist
- CRNA service w/ OR w/o medical direction by physician
- Residents under a Staff's direction

Note: Coding drugs/agents-Currently these are included in the facility charge captured with the 99199 in the last or fourth position of the Surgeon's SADR. APV's Only!

Anesthesia Coding not covered in DoD Rules



- MRI's
- Clinic encounter (out patient)
- Emergency or Critical Care

Example: Radiology Code in D MEPR

Anesthesia Code in D MEPR (DFAA) **AF ONLY**

Example: E&M Code in B*** MEPR

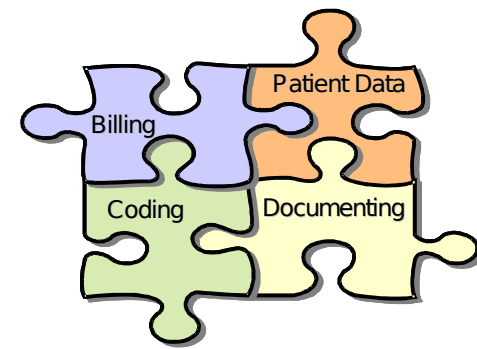
Anesthesia code in D MEPR (DFAA) **AF ONLY**

Facility captures Anesthesia workload

Although it is inappropriate to report anesthesia with some E&M medicine or radiology codes, there are situations where medical necessity require anesthesia.

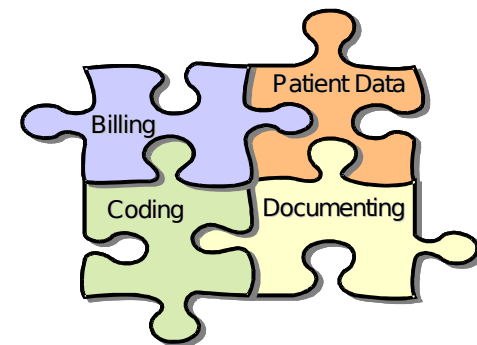
Report these with a modifier 23

Coding Errors



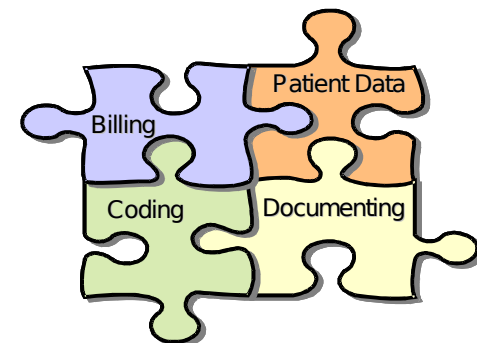
- Code does not match diagnosis
- Code does not match procedure
- In-appropriate use of add on codes
- Specificity of general anesthesia administration
- Location

Anesthesia Codes



- General - between 00100 and **01969**
- Other procedures 01990-01999
- Qualifying Circumstances 99100-99140 (add on codes)
- Pain Management and Nerve Blocks
 - 01995-01996, 20526, 20550-20553, 20600-20610, 27096, 62263-62264, 62270, 62273-62282, 62310-62350, 62355-62368, 63650, 63660-63688, 64400-64530, 64600-64614, 64620-64681, 72275, 73542, 76003-76005
- Invasive Monitoring
 - 36488-36491 deleted, 36555-36561, 36580, 36584, 36620-36625, 93503
- Transesophageal Echocardiography 93312-93318
- Neurological Monitoring 95955

Anesthesia Codes



Special Coding Situations - CPT Expert 2005

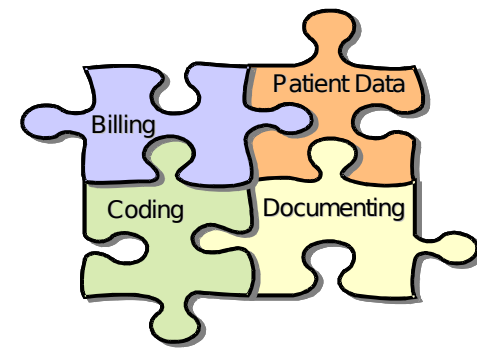
- Multiple Procedures
- Additional Procedures
- Unusual Monitoring
- Prolonged Services
- Post Operative pain management
- Monitored Anesthesia
- Obstetrical Anesthesia
- Regional Anesthesia
- Unusual Anesthesia
- Chronic Pain Management Services

Note: Be familiar with this section as it defines the assignment of the codes on the previous slide.

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Business Office Conference 2005

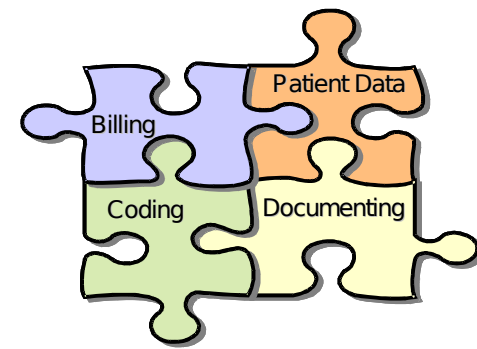
Anesthesia Modifiers



- **Level I Modifiers**

- P1 - Normal healthy patient
- P2 - Pt w/mild systemic disease
- P3 - Pt w/severe systemic disease
- P4 - Pt w/ severe systemic disease that is a constant threat to life
- P5 - Moribund pt not expected to survive w/o operation
- P6 - Declared brain-dead pt whose organs are being removed for donor purposes
- 23 - Unusual anesthesia

Anesthesia Modifiers



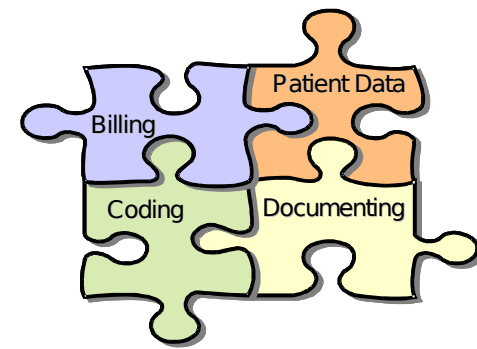
- **Level II Modifiers**

- AA - anesthesia service performed personally by anesthesiologist
- AD - medical supervision by a physician; more than 4 concurrent anesthesia procedures
- G8 - Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
- G9 - Monitored anesthesia care (MAC) for patient who has history of severe cardiopulmonary condition
- QK - Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals
- QS - Monitored anesthesia care (MAC) service (see G8 and G9)
- QX - CRNA service: with medical direction by a physician
- QY - Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
- QZ - CRNA service: without medical direction by a physician

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Business Office Conference 2005

References



Army

<http://www.pasba.amedd.army.mil>

Air Force

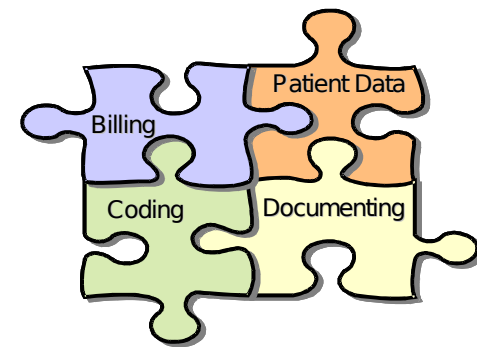
<https://phsohelpdesk.brooks.af.mil>

1-800-298-0230

Navy

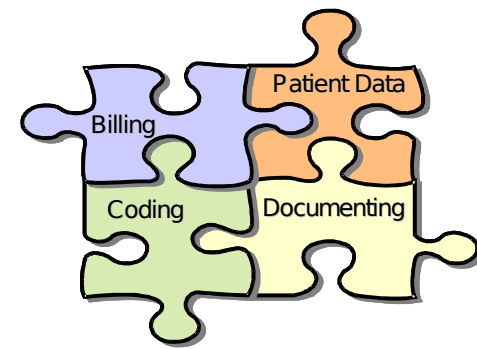
<https://imcenter.med.navy.mil/045department/>

Resources

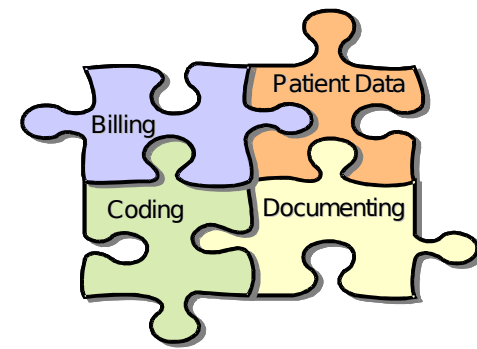


- 2005 CPT Expert
- DoD Coding Guidelines
- DoD Functional Business Rules
- Several Really Smart Coders!!!!

Summary

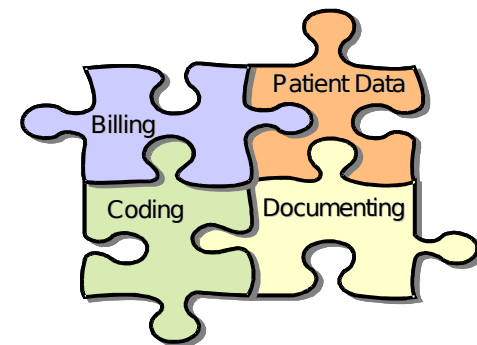


- Defined anesthesia types
- Anesthesia providers
- Civilian vs. Military Coding
- Workload Capture
- Common coding errors



Questions

??????????

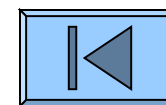


MEPRS 101

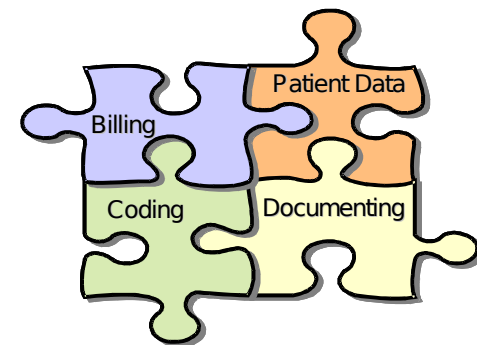
Jerry Baker, *MS, FACHE*

18 May 05

UBU Basic

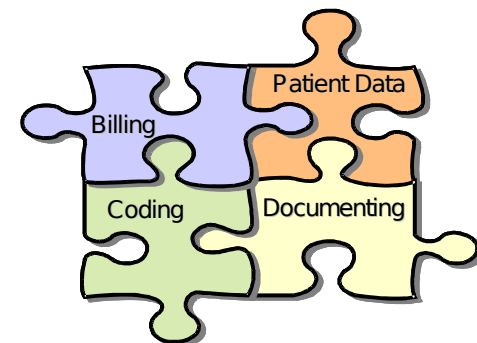


Outline



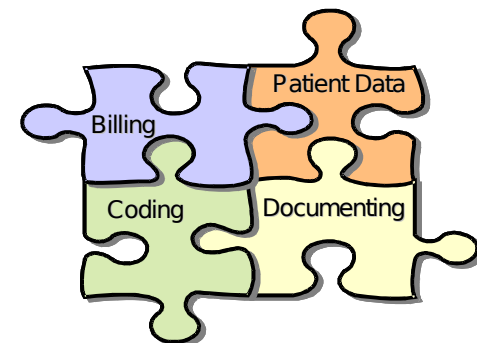
- Introduction
- MEPRS Data
- MEPRS Account Structure
- Expense Allocation
- Data Quality

Introduction



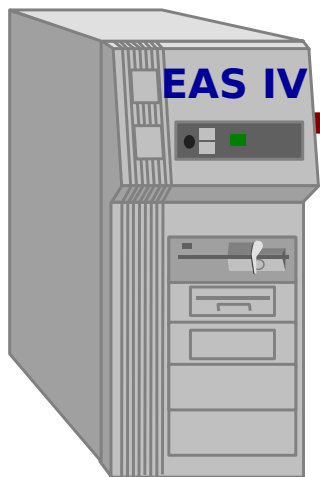
- **MEPRS:** Medical Expense & Performance Reporting System
- **Origin of MEPRS:**
 - Evolved from two historical systems
 - the Uniform Chart of Accounts (UCA), and
 - the Uniform Staffing Methodologies (USM)
 - UCA focused on tracking **expenses**
 - USM was concerned with **manpower** resources
 - In January 1985, the two systems were combined and the “MEPRS System” was born.

Introduction

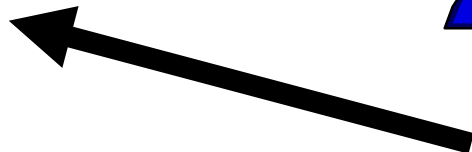


MEPRS Data:
DoD-
Standardized,
Aggregated by
FCC

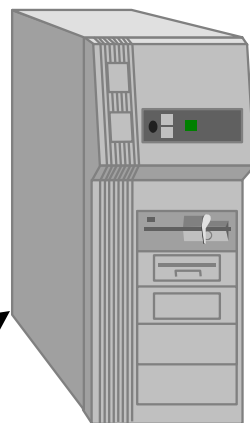
- Service-specific financial data
 - Army: STANFINS
 - Navy: STARS/FL
 - Air Force: BAFS
- Service-specific personnel data
 - Army: UCAPERS
 - Navy: SPMS
 - Air Force: AF Personnel Sub-System of EAS
- Workload
 - CHCS / WAM



EAS IV Repository
Access via
Business Objects



EAS IV Repository--
DoD- Standardized
MEPRS Data



Service Financial
System

- O&M Expense
- Civilian Salary
- Obligation data
- PEC data

WAM

Local MTP
EAS IV

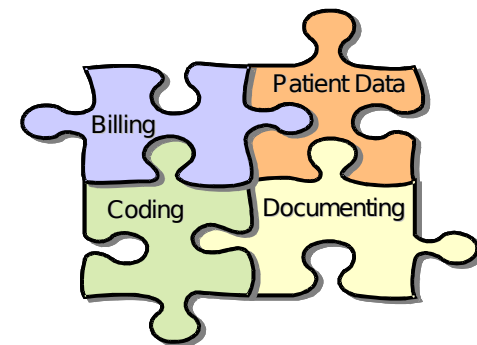
Composite Health Care
System (CHCS)

- Admissions/Discharges
- Bed Days
- Visits
- Ancillary Workload

Service Personnel
System

- Manpower data
- MILPERS

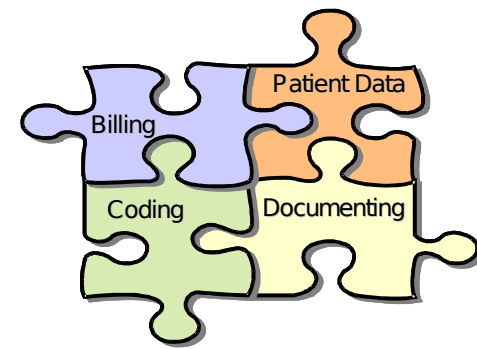
Introduction



- MEPRS = Information
- EAS = *Expense Assignment System*: Hardware and Software in which the information resides

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MEPRS Financial Data

Financial Data

- Kinds of Dollars

- Pay Data

- Military
 - Civilian

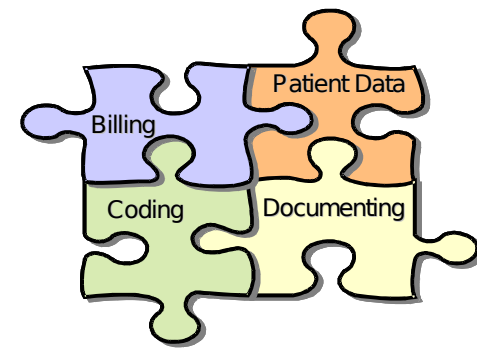
- Contracts

- Supplies

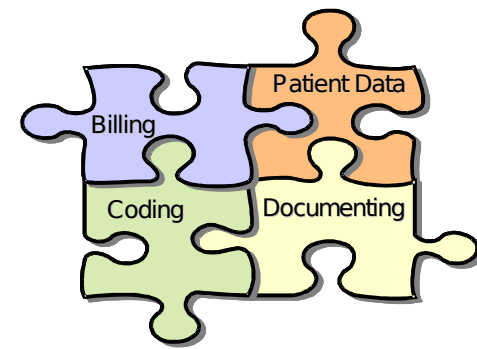
- Equipment

- Base Operations

- Depreciation



Financial Data



- Pay Source Differences

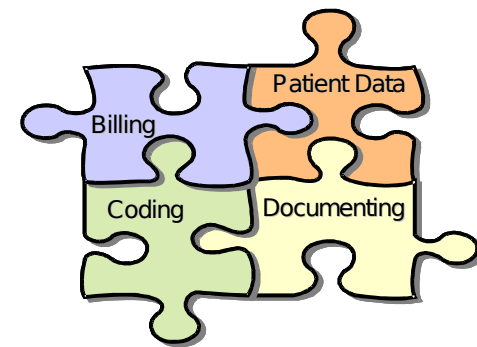
- Military Pay

- Service-specific Composite Military Pay Tables
 - Special Pays not medical-unique

- Civilian Pay

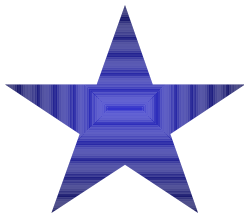
- Army / Navy use actual pay from Service financial system
 - Air Force uses Composite Civilian Pay Tables

Financial Data



- DoD-standardized financial data:

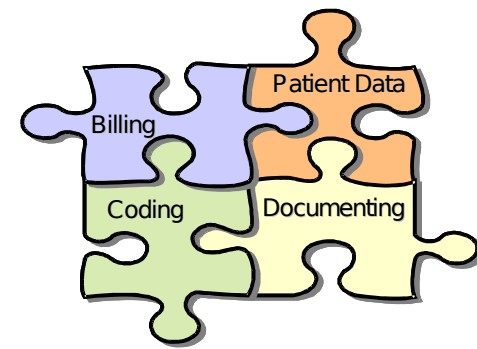
DoD	Air Force	Army	Navy
SEEC - Standard Expense Element Code	EEIC - Element of Expense Investment Code	EOR - Element of Resource	EE - Expense Element
PEC - Program Element Code	PEC - Program Element Code	AMSCO - Army Management Structure Code	SAG - Subactivity Group



Service-specific pure financial data are also available in the EAS IV Repository

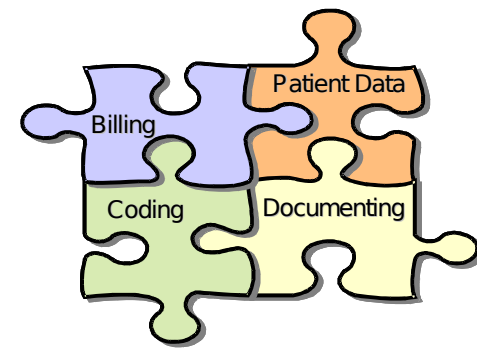
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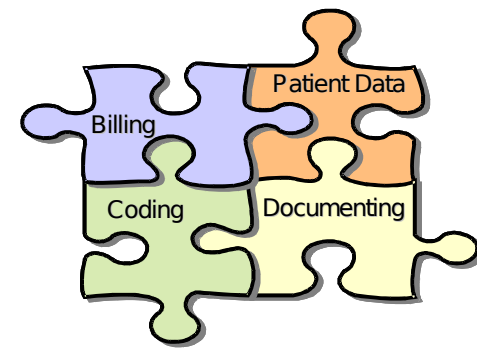
MEPRS Personnel Data

Personnel Data



- Full Time Equivalent (FTE)
 - Amount of labor available to the MTF work center if a person works 1 month
 - 168 Man-Hours = 1 FTE
(Avg. 21 Days/Month x 8 Hours)
- Assigned FTEs
 - Listed on facility manning documents
- Available FTEs
 - Includes assigned, attached, borrowed, contracted, volunteers
- Non-Available FTEs
 - Leave, sick

Personnel Data



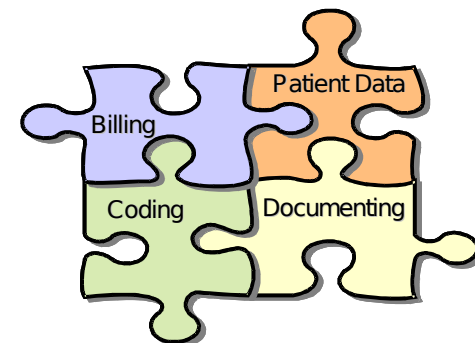
Total FTEs (Assigned /
Available)

Personnel
Category

Skill Type

Skill Type
Suffix

Personnel Data



Total FTEs

Personnel
Category

Skill Type

Skill Type
Suffix

Officer
Enlisted
Civilian
Contract
Other

Clinicians

Direct Care
ProfessionalsRegistered
NursesDirect Care
Para-
professionalsAdmin/
Clerical/Log

Physician
Dentist
Medical
Resident
Medical
Fellow
Medical
Intern
Dental
Intern
Dental
Fellow

Physician
Assistant
Nurse
Practitioner
Nurse Midwife
Nurse
Anesthetist
Community
Health
Occupat. Health
Nurse
Business Office
Nurse

Registered
Nurse
Other

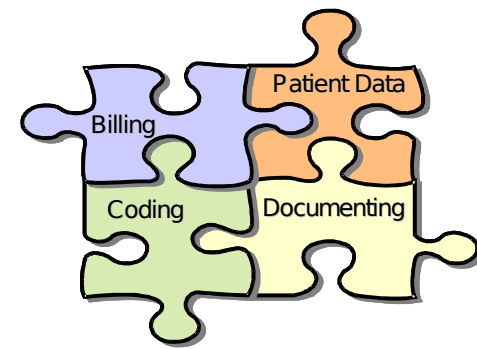
LPN or LVN
Nursing
Assistant
Other

Logistics
Clerical
Administrat
or
Other

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Business Office Conference 2005

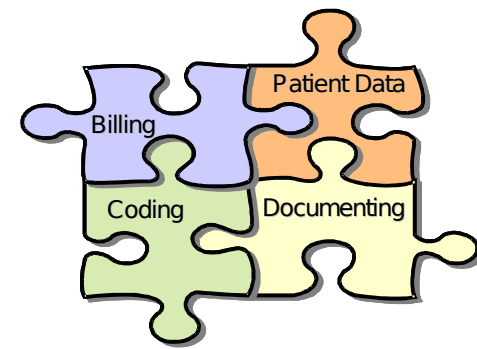
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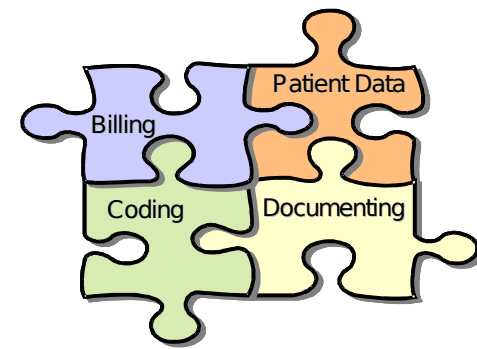
MEPRS Workload Data

Workload Data



- With few exceptions (e.g., biomedical equipment repair), the source of MEPRS workload data is CHCS
- The Workload Assignment Module (WAM) of CHCS **automates the interface with EAS**
- Workload data includes beneficiary category and Current Procedural Terminology (CPT) data

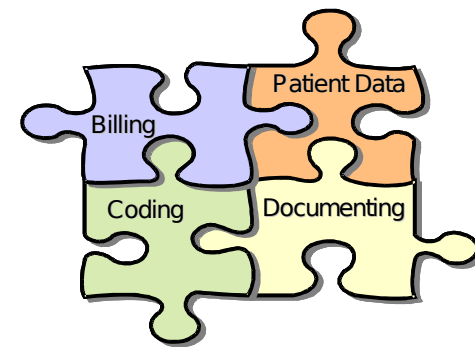
Workload Data

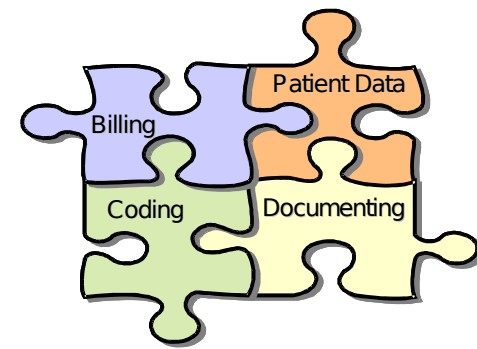


- Inpatient Services (A)
 - Admissions
 - Dispositions
 - Occupied Bed Days
 - Bassinet Days
- Ambulatory Services (B)
 - Ambulatory Visits
 - Evaluation & Management (E&M) Codes
 - CPT Codes

Workload Data

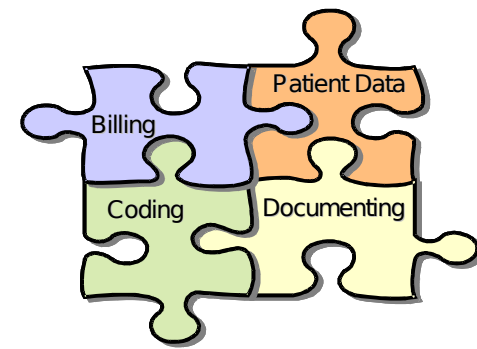
- Dental Services (C)
 - Composite Time Values
 - Composite Lab Values
- Ancillary Services (D)
 - Raw and Weighted Procedures
 - Minutes of Service (Surgical Services)
 - Hours of Service (ICU)
 - CPT-4 Codes (EAS IV)
- Special Programs (F)
 - Immunizations
 - Visits





MEPRS Account Structure (Functional Cost Codes)

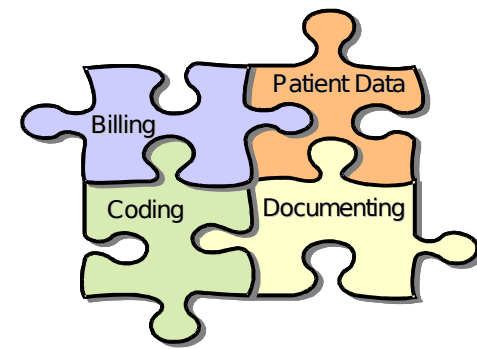
MEPRS Account Structure



Functional Cost Codes (FCCs):

- 4-letter MTF-specific codes representing **work centers** or reporting facilities; used to track costs, workload and FTEs
- First 3 letters are DoD-standard

MEPRS Account Structure: FCCs



- The **first letter** of an FCC identifies the type of service provided:

A - Inpatient Care

B - Ambulatory Care

C - Dental Care

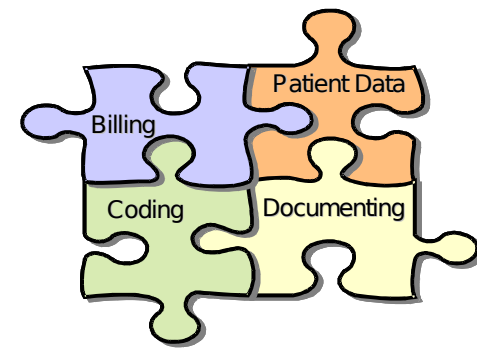
D - Ancillary Services

E - Support Services

F - Special Programs

G - Medical Readiness

MEPRS Account Structure: FCCs



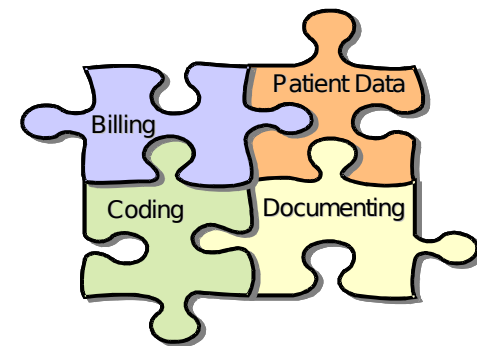
- The **second letter** identifies Summary Accounts within a service; e.g.,

B = AMBULATORY CARE

- BA = Medical Care
- BB = Surgical Care
- BC = Obstetrical//Gynecological Care
- BD = Pediatric Care
- BE = Orthopedic Care
- BG = Family Practice Care
- BH = **Primary Medical Care**

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MEPRS Account Structure: FCCs

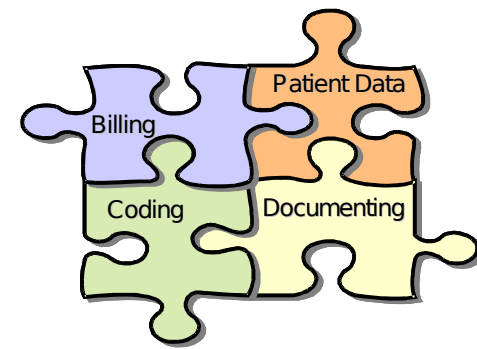


- The **third letter** identifies particular work centers within Summary Accounts; e.g.,
 - B = AMBULATORY CARE
 - BH = PRIMARY MEDICAL CARE
 - BHA = Primary Care Clinics
 - BHB = Medical Examination Clinic
 - BHC = Optometry Clinic
 - BHE = Speech Pathology Clinic
 - BHF = Community Health Clinic
 - BHG = Occupational Health Clinic

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MEPRS Account Structure: FCCs

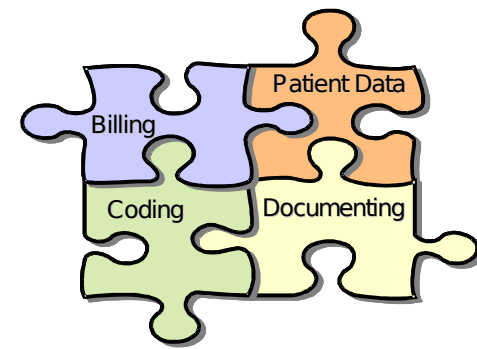


- The **fourth letter** is MTF-unique and used to identify specific types of costs & workload; e.g.,
 - B = AMBULATORY CARE
 - BH = PRIMARY MEDICAL CARE
 - BHA = Primary Care Clinics
 - » BHAA = Primary Care Clinic – Parent Facility
 - » BHAM* = Primary Care Clinic - TMC-1
 - » BHAW* = Primary Care Clinic - TMC-5

*United Biostatistical Utility/Uniform

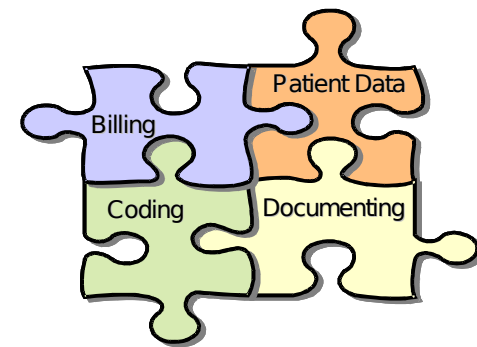
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Expense Allocation

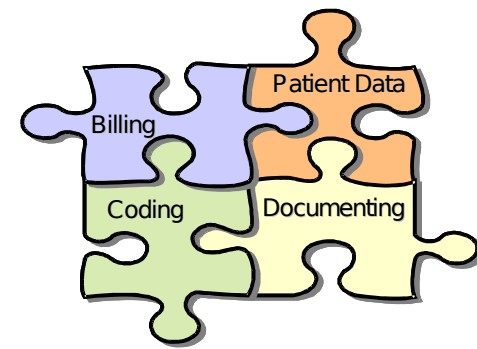
Expense Allocation



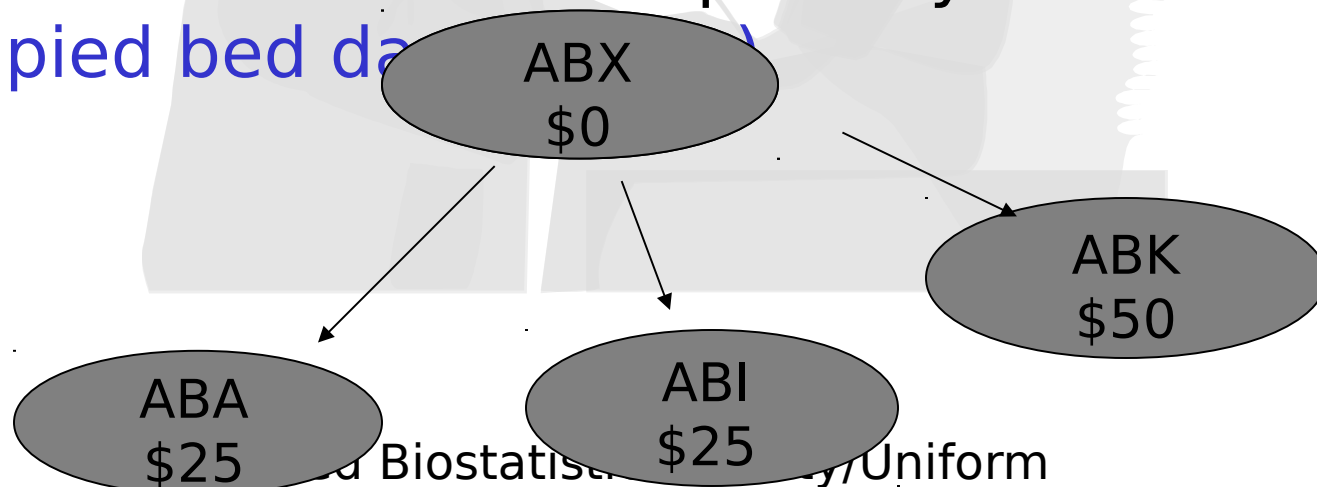
- Cost Pools

- Cost pools are identified with an “X” in the 3rd FCC position.
- Used when time and expense cannot be specifically assigned because two or more work centers share space, personnel or supplies. For example, **mixed wards**.
- Expenses and FTEs in cost pools are reassigned (**purified**) on the basis of workload.

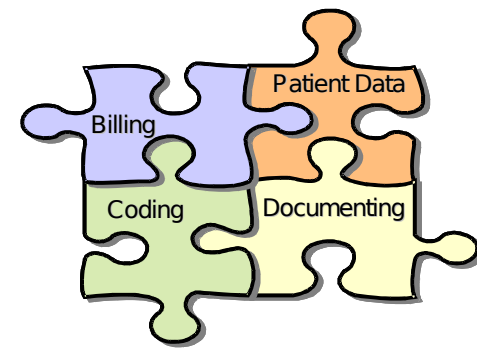
Expense Allocation



- Ward 3E has a supply closet shared by three specialties -- **Cost Pool ABX**
 - ABA - General Surgery (25 OBDs)
 - ABI - Plastic Surgery (25 OBDs)
 - ABK - Urology (50 OBDs)
- Supply costs accumulated in ABX (\$100) are purified based on each specialty's Ward 3E **occupied bed days**

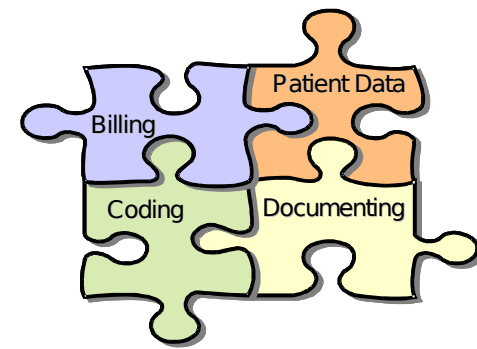


Expense Allocation



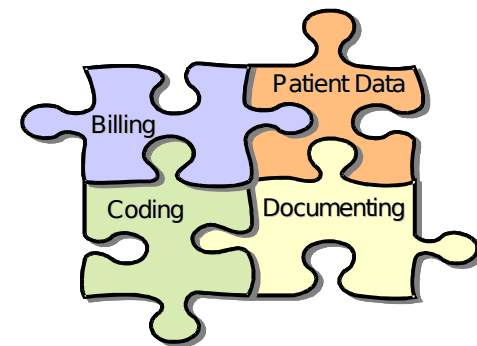
- Final Operating Accounts
 - A - Inpatient Care
 - B - Ambulatory Care
 - C - Dental Care
 - F - Special Programs
 - G - Medical Readiness
- Intermediate (Stepdown) Accounts
 - D - Ancillary Services
 - E - Support Services

Expense Allocation

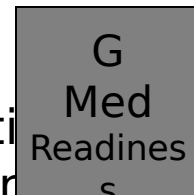
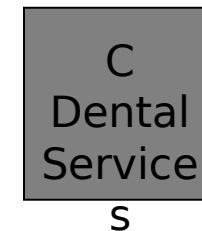
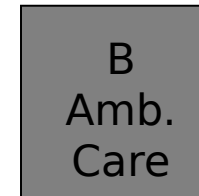
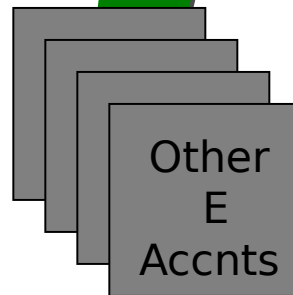


- Support Services (E) and Ancillary Services (D) costs are allocated (stepped down) across final operating accounts
- Costs are allocated based on performance factors established by DoD 6010.13M
 - Weighted procedures performed
 - Hours / Minutes of Service performed
 - Square footage cleaned

Expense Allocation



First, Support Services (“E” accounts) expenses are allocated



Each Support Service FCC is allocated until no expenses remain in “E” accounts

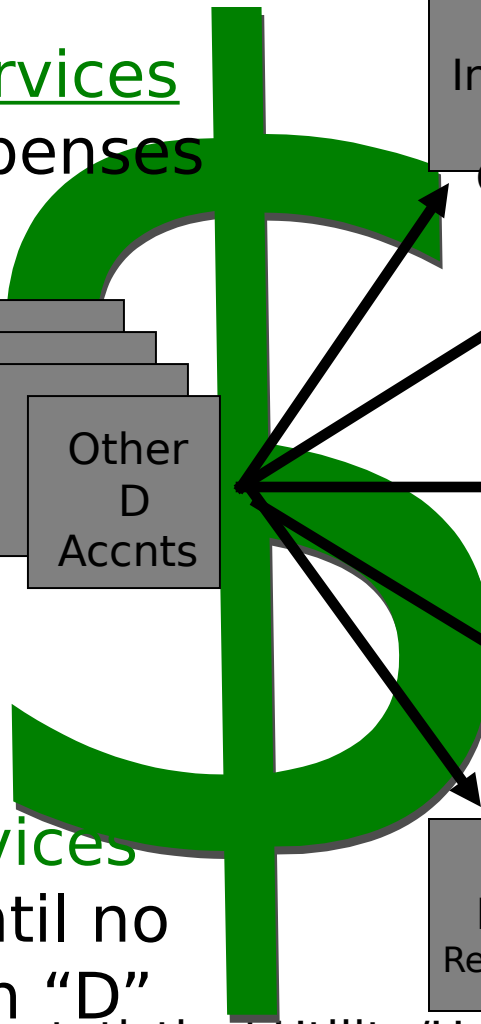
Expense Allocation

Then, Ancillary Services ("D" accounts) expenses are allocated

D
Ancillary
Services



Other
D
Accnts



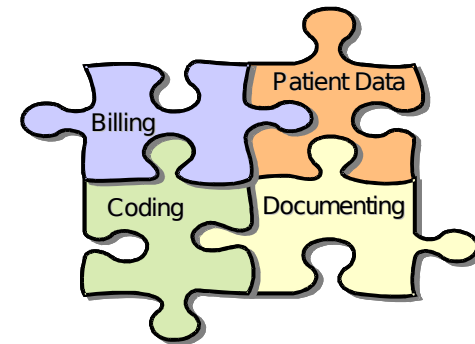
A
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B
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Care

C
Dental
Services

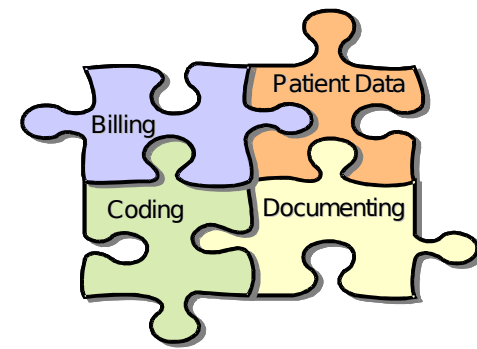
F
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G
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Each Ancillary Services FCC is allocated until no expenses remain in "D" accounts

Total Expenses

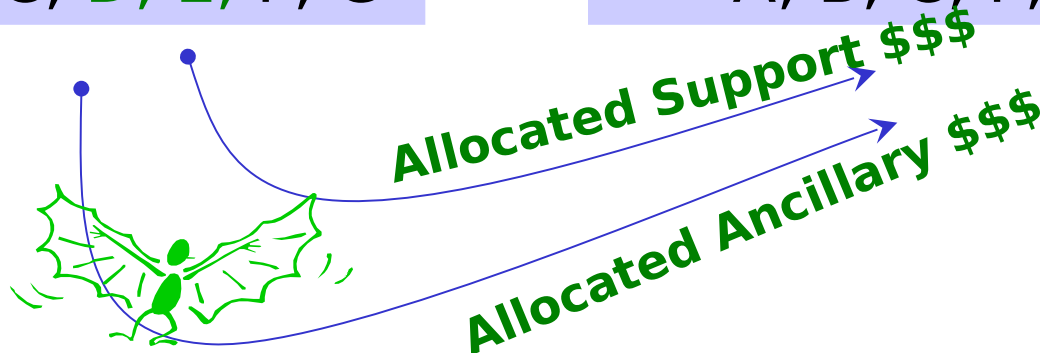


Direct Expenses
A, B, C, **D, E**, F, G

=

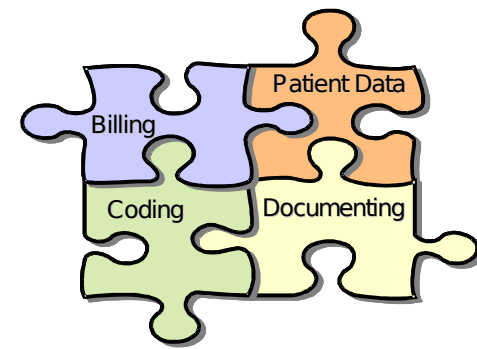
**After Purification of
Cost Pools and
Allocation of D & E
Accounts**

Total Expenses
A, B, C, F, G



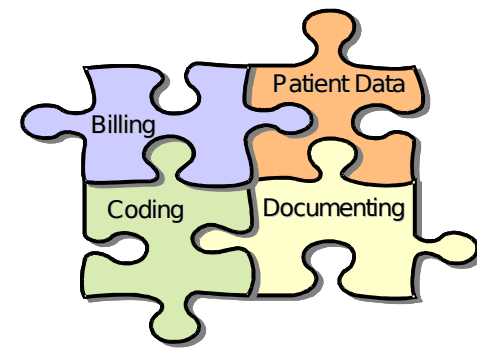
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MEPRS Data Quality

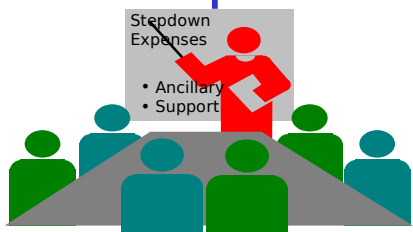
MEPRS Data Quality Challenge



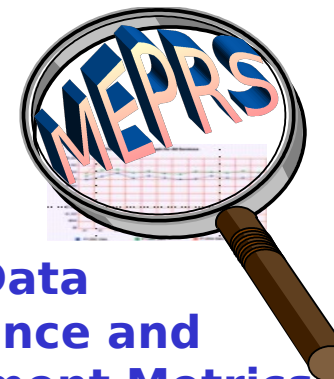
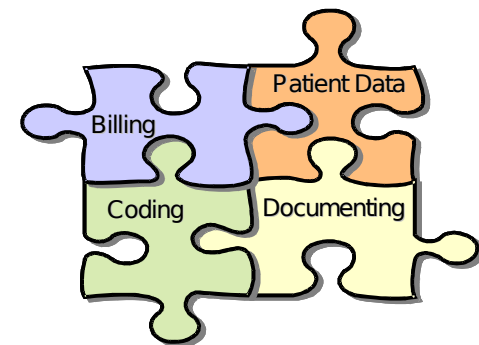
- Data quality issues in MEPRS generally result from:
 - Insufficient vigilance or attention to data quality
 - Lack of effective education and training
 - Inconsistent implementation of policies, guidelines and business rules
 - System-related issues -- transmission or processing errors

MEPRS Data Quality Challenge

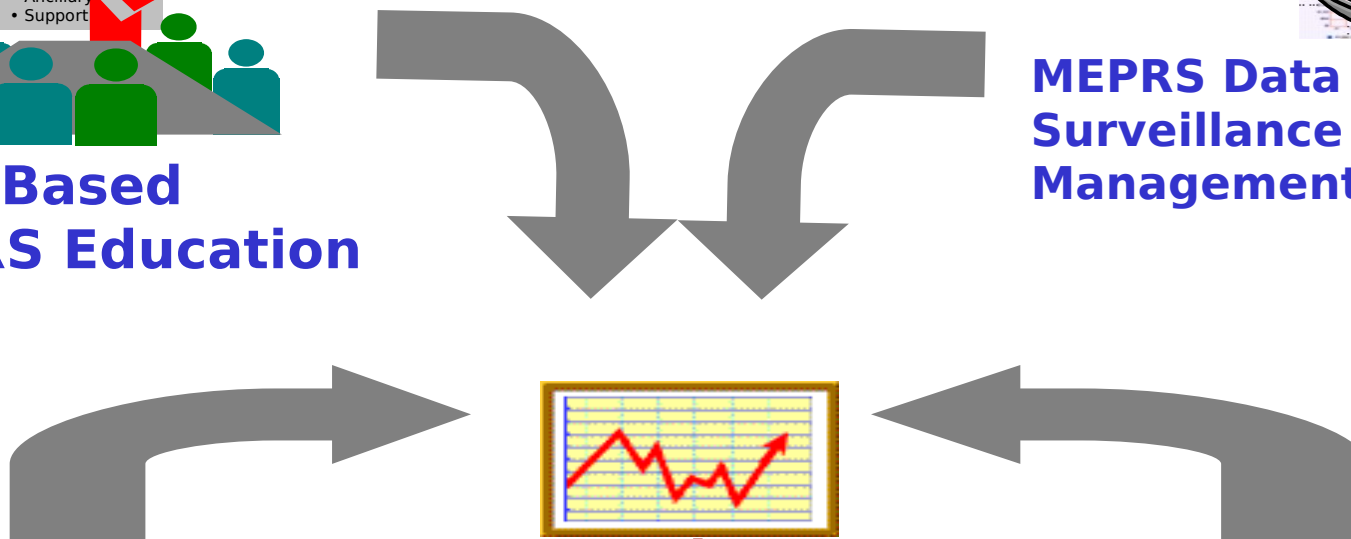
Active Feedback and
Continuous Process
Improvement



**Data-Based
MEPRS Education**



**MEPRS Data
Surveillance and
Management Metrics**



**Improved MEPRS
Data Quality**

**MEPRS
Information
Sharing**



**MEPRS Policy
and Business
Rules
Oversight**

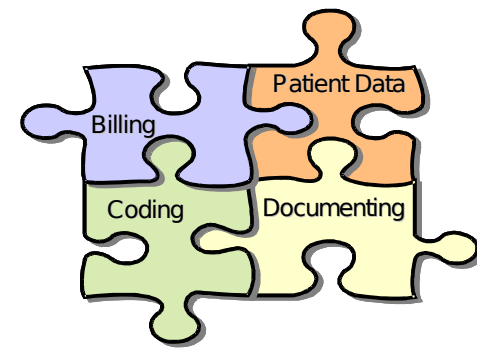


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Unified Biostatistical Utility/Uniform
Business Office Conference 2005

MEPRS Training, Education and Information Sharing



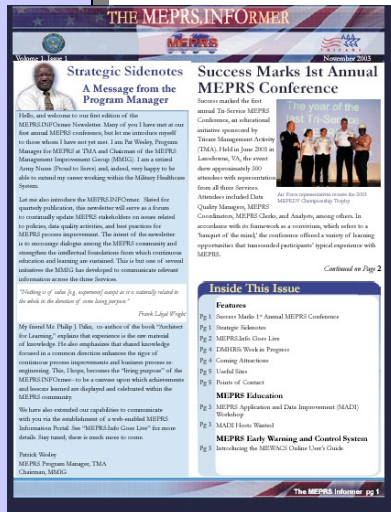
- Tri-Service **MEPRS Application and Data Improvement (MADI)**

workshop FY04 attendance: 89

- **2004 National MEPRS Conference** attended by 200+

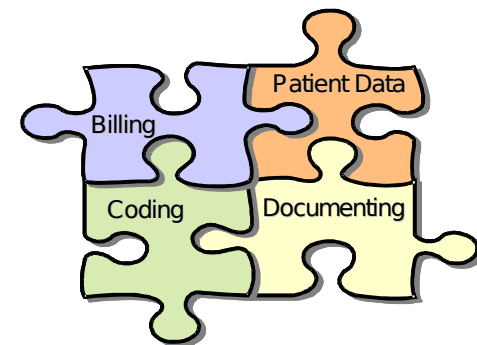


- **MEPRS.INFOrmer** is the new MEPRS quarterly newsletter launched 1Q FY04
- Updates **MEPRS stakeholders** on policy issues, data quality activities, and best practices for MEPRS process improvement
- **MEPRS Conference Exhibit** provides thousands of MHS personnel the opportunity to interact with centrally available MEPRS tools and metrics, and learn about resources available through the MEPRS Information Portal



Unified Biostatistical Utility/Uniform
Business Office Conference 2005

MEPRS Information Web Portal



- The **www.MEPRS.INFO** web portal is hosted at the TRICARE web server -

www.tricare.osd.mil

MEPRS Workshops
Info & Registration

MEPRS Newsletter
MEPRS.INFOrmer

Data Quality
Surveillance
MEWACS

2004 MEPRS
Conference

MEPRS Manual
DOD 6010.13-M

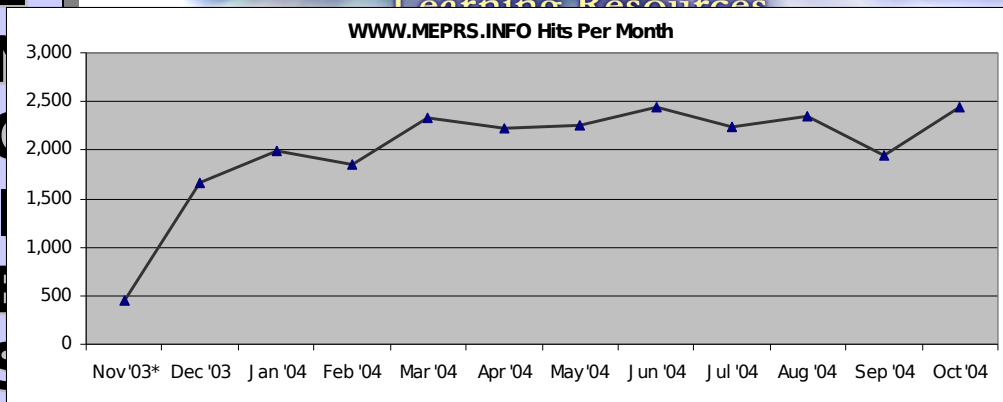
Six Sigma
MEPRS Management
Metrics (S2M3)

MMIG
Minutes & Briefings

Human System
Interface (HSI)

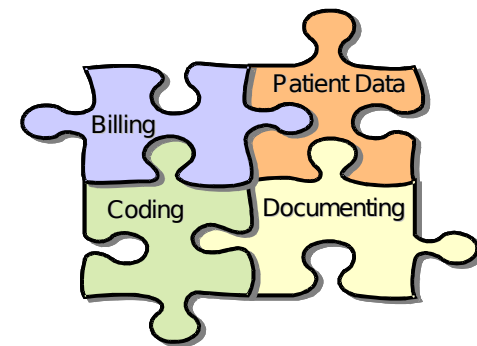
MEPRS
Learning Resources

- The MEPRS Information Portal is the **gateway** to MEPRS-related resources, including **policy documents, learning materials, data quality surveillance tools, metrics, and much more**



- Tri-Service utilization continues strong as demonstrated by monthly traffic metrics

MEPRS Data Quality Surveillance and Management Metrics



- **MEWACS** provides monthly MEPRS data quality feedback, systematically highlighting potential MTF data anomalies
- **Human Systems Interface (HSI)** provides expert data quality and analysis assistance to field, serving as the link between MEPRS education and data quality surveillance initiatives.

Six Sigma MEPRS Management Metrics (S2M3)

MEPRS.INFO
MEDICAL EXPENSE & PERFORMANCE REPORTING SYSTEM

MTF Data Profiles
This tab displays up to 24 fiscal months of descriptive data for the following variables: Dispositions, Total Visits, Available FTEs, Assigned Direct Expenses per Assigned FTE. For additional information, consult the MEWACS Online User's Guide.

Define Search Criteria

Service:

Region/HSO/MAJCOM:

Parent DMISID:

FCC Code:

Press the "Submit" button after defining your search criteria or "Contact Us" if you have further questions.

Showing Results for 3rd MED GRP-ELMENDORF

Data Type	FY 2002	01	02	03	04	05	06	07	08	09	10	11
Dispositions	294	249	307	247	236	284	266	258	289	312	2	
Total Visits	66	67	64	66	66	65	67	67	65	67	7	
Assigned FTEs	67	63	67	66	61	67	59	65	59	60	6	



Data Current as of: 22 Oct 2003



*** DRAFT ***

Click on a peer group below to view a specific metric:

Rx Dispensing Costs	Assigned FTE per Daily Occupied Bed	Ratio of Support Personnel to Provider FTEs	Rx Workload per Rx FTE	Lab Workload per Lab FTE	Inpatient Costs per RWP	Ambulatory Costs per APG
Medical Centers	Medical Centers	Medical Centers	Medical Centers	Medical Centers	Medical Centers	Medical Centers
Large Hospitals	Large Hospitals	Large Hospitals	Large Hospitals	Large Hospitals	Large Hospitals	Large Hospitals
Small Hospitals	Small Hospitals	Small Hospitals	Small Hospitals	Small Hospitals	Small Hospitals	Small Hospitals
Clinics	Clinics	Clinics	Clinics	Clinics	Clinics	Clinics

Executive Summary:

[Medical Centers](#)
[Large Hospitals](#)
[Small Hospitals](#)
[Clinics](#)

Notes:

[Six Sigma Description](#)
[Definition of Metrics](#)
[Data Sources](#)
[Peer Group Definitions](#)

External MEPRS Resources:

[MEPRS Web Portal](#)
[MEWACS](#)
[MEPRS Manual DoD 6010.13-M](#)
[Human System Interface \(HSI\)](#)

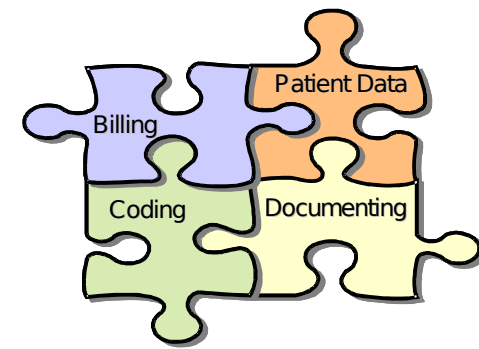
MTF-Peer Group Lookup:

[Air Force](#)
[Army](#)
[Navy](#)

- The **Six Sigma MEPRS Management Metrics (S2M3)** workbook is an interactive tool containing seven key MEPRS-based performance metrics
- S2M3 is a blend of **Direct Care and civilian industry** benchmark metrics
- Updated Semi-annually on the FY

cal Utility/Uniform

MEPRS Policy & Business Rules Oversight



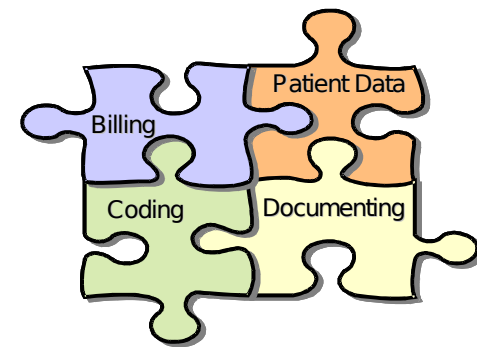
• DoD 6010.13M

- Provides Tri-Service guidance to all MEPRS reporting MTFs / DTFs
- Contains policy and guidance for implementation of MEPRS program
- Download from/access Online: www.meprs.info

Chapter 1:	Background
Chapter 2:	Chart of Functional Cost Codes
Chapter 3:	Manpower & Expense Assignment
Chapter 4:	Reporting Requirements
Chapter 5:	MEPRS Issue Process
Appendices	Acronyms, Definitions, Guidelines for Reporting Data

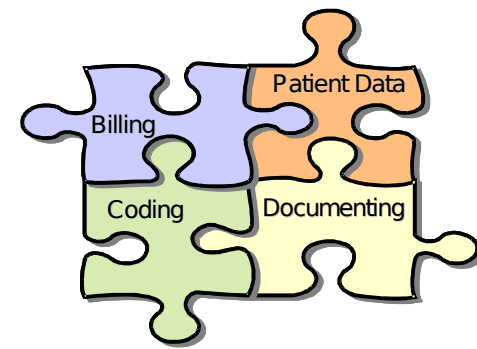
Unified Reporting Data Utility/Uniform

MEPRS Policy & Business Rules Oversight



- **MEPRS Management Improvement Group (MMIG)**
 - Established in 1999
 - Provides Functional Oversight
 - Tri-Service Integration, Standardization and Compliance
 - Automated Information System Oversight
 - Coordinates Policy / Action with Resource Management Steering Committee (RMSC)
 - Meeting Minutes and Information on www.meprs.info

Issue Identification / Resolution



HA / TMA Directorates

TMA Program
Offices (CITPO /
RITPO)

Chartered
Workgroups (UBU /
UBO)



Service MEPRS POCs



NMIMC

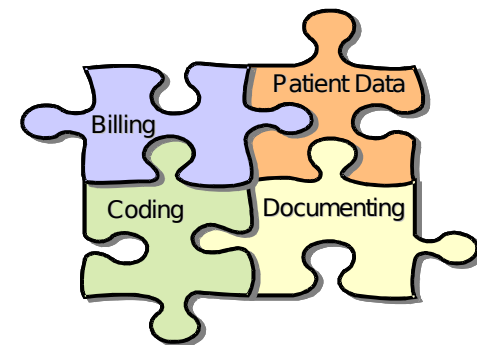
MEDCOM

Gunter AFB

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Business Office Conference 2005

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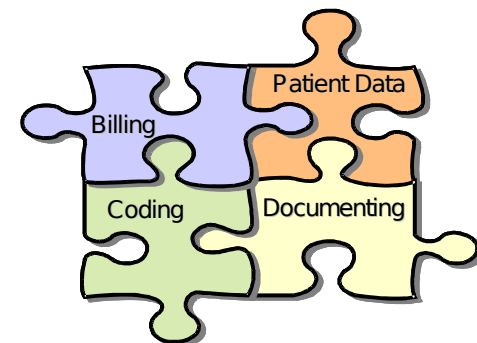
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MEPRS 101

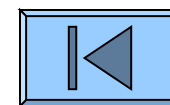
Q & A

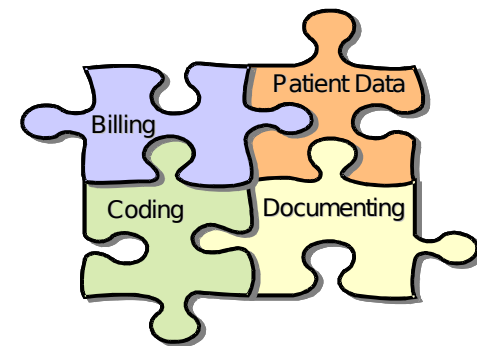
Jerry Baker
gerald.baker@tma.osd.mil
703-681-3492 X4064



FAP/ADAPT/BHOP (Mental Health Programs)

Laurie A. Beauchamp
USAFE Medical Coding
Auditor, MAJCOM

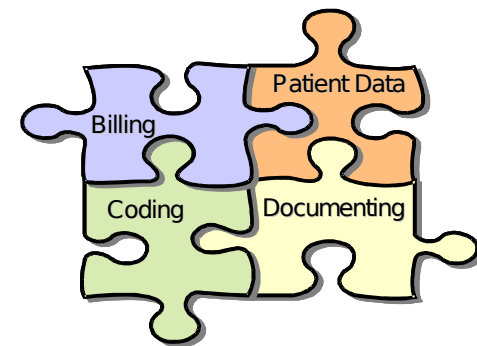




Objectives:

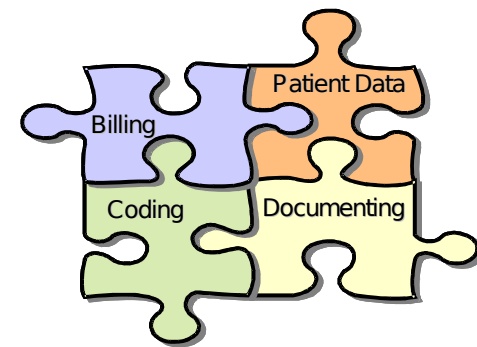
- Define Who Can Code
- Confidentiality Concerns and Documentation
- Define What Services Can Be Coded
- Define Difference Between ICD-9 and DSM-IV
- Discuss Modifiers

Provider



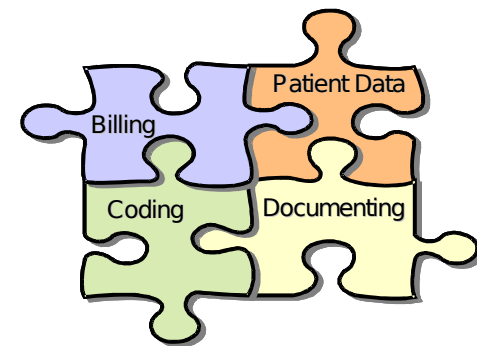
- Psychiatrist – Physician
 - Evaluation and Management Services
 - Medication Management
 - All Other Services

Providers



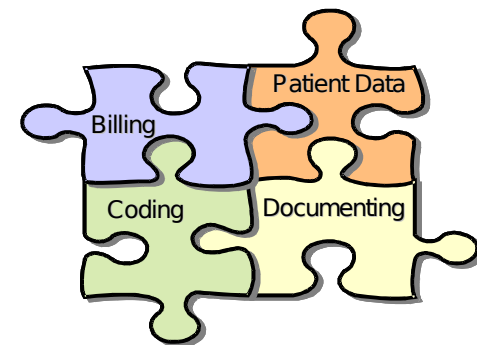
- Clinical Psychologist
 - Testing
 - Therapy
 - Assessments
 - Preventive services

Providers



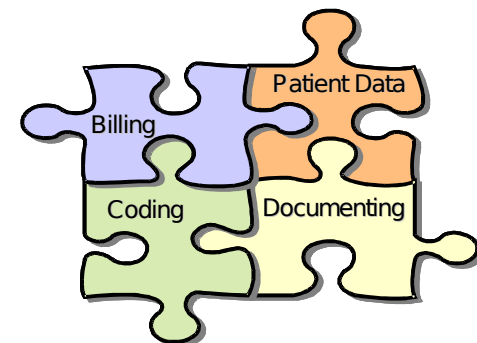
- Clinical Social Worker
 - Therapy
 - Assessments, if trained and licensed
 - Preventive services

Providers (Extent Licensed)



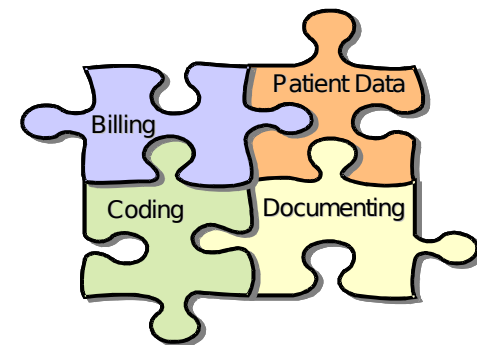
- Nurse Practitioner
- Clinical Nurse Specialist
- Physician Assistant

Definitions:



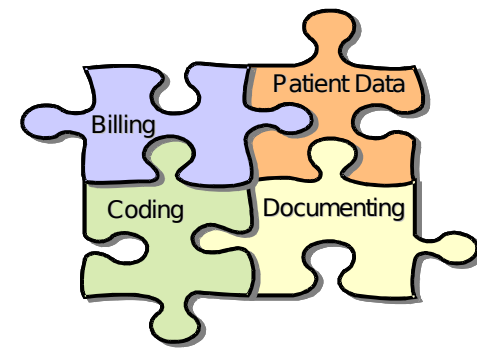
- Provider - Privileged Healthcare Professional
- Encounter – Client Visit
- Diagnosis – Mental Disorder

Privacy Concerns:



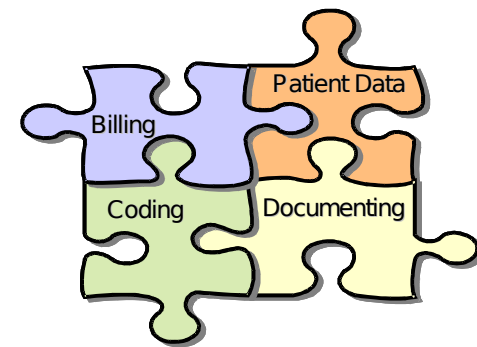
- Therapist – Client Confidentiality
- HIPAA

Therapist - Client



- Same as Physician – Patient
- All Information Held as Confidential

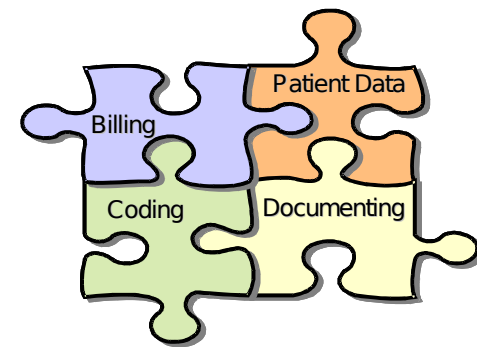
HIPAA



- Special Category of Confidentiality

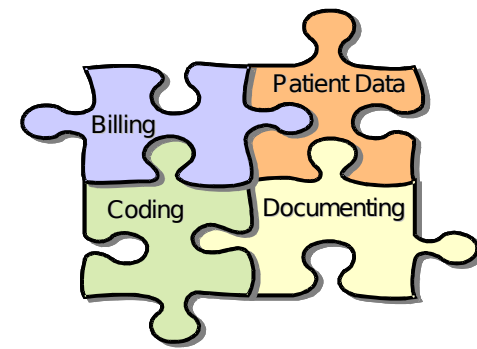


HIPAA



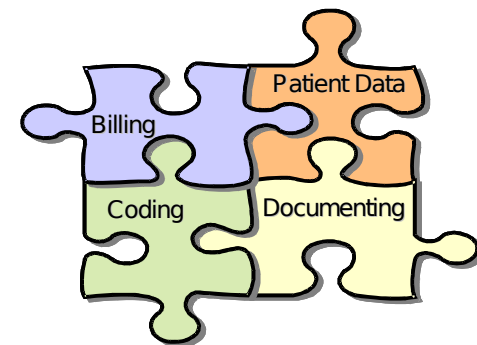
- Summaries of the following:
 - Diagnosis
 - Functional Status
 - Treatment Plan
 - Symptoms
 - Prognosis
 - Progress to Date

Documentation Requirements:



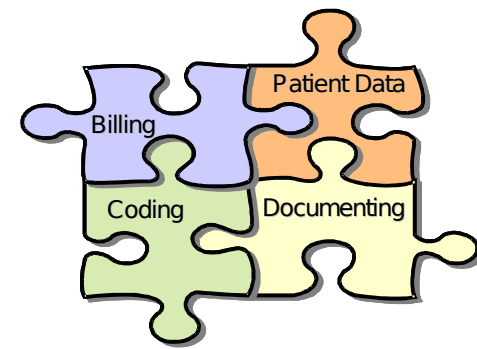
- Medical Necessity
=
- Evidence of Mental Illness
=
- Diagnosis

Diagnosis



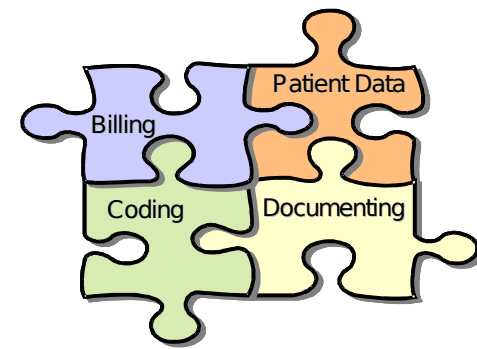
- Coding Guidelines
 - Definitive
 - No rule out/probably/suspected
 - Symptoms
 - Code Also Contributing Factors

Documentation



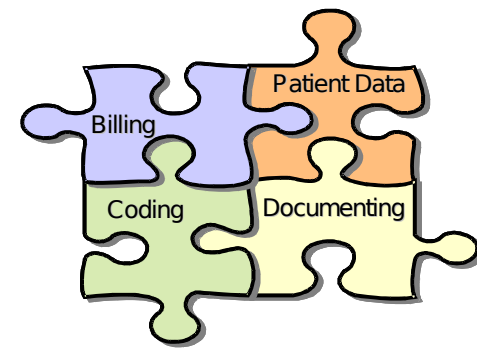
- DHHS Standards
 - Date of Service
 - Diagnosis
 - Critical Elements of Therapy
 - Signed
 - Legible

Documentation



- Critical Elements of Therapy:
 - Symptoms
 - Goals of Therapy
 - Client's Ability to Participate / Benefit
 - Time
 - Treatment Plan

Coding Therapy Encounters

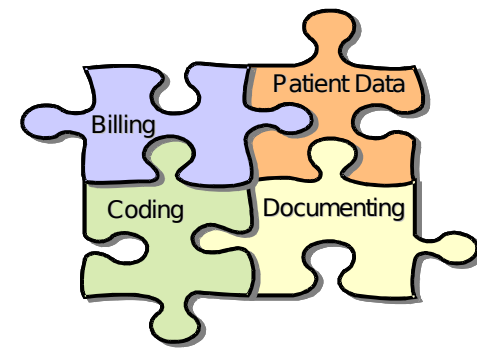


Time is Face to Face

No Paperwork or Telephone

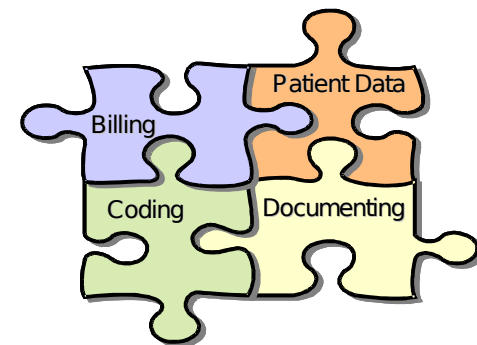


Psychiatric Interview



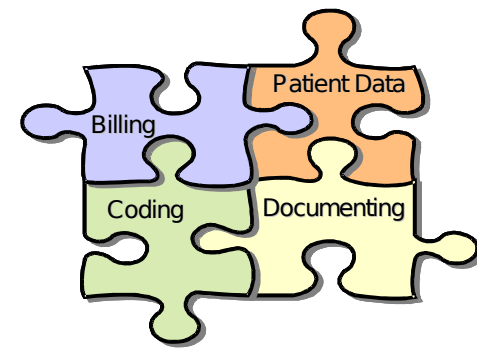
- Includes:
 - History
 - Mental Status
 - Disposition
 - Diagnostic Studies

Coding Psychiatric Interview



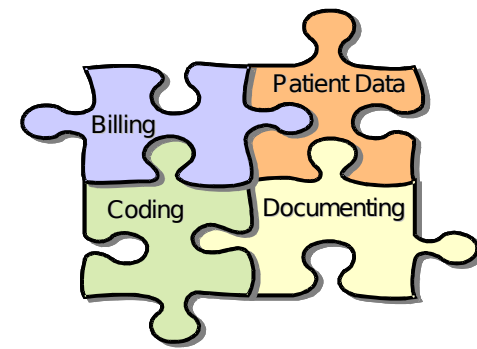
- 90801
- Performed by physician
- Coded once

Coding Therapy Encounters - Individual



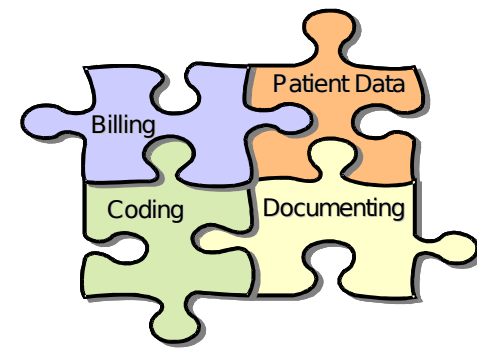
- 90804
 - 20 to 30 minutes
- 90806
 - 45 to 50 minutes
- 90808
 - 75 to 80 minutes

Coding Therapeutic Services with E/M



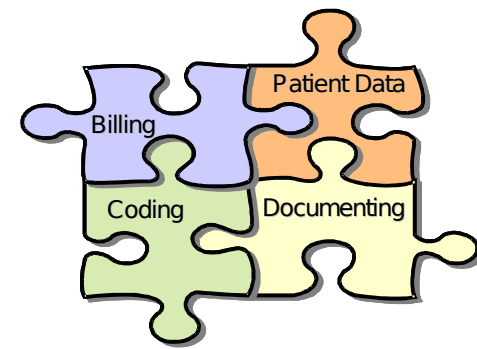
- Documentation Requirements Apply
- E/M Documentation Guidelines Apply

Coding Therapeutic Services with E/M



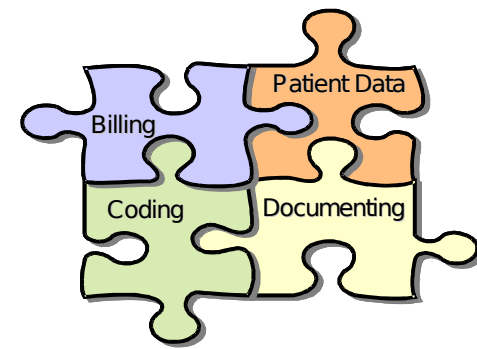
- 90805 - Individual
 - 20 to 30 minutes
- 90807- Individual
 - 45 to 50 minutes
- 90809 – Individual
 - 75 to 80 minutes

Choosing an Encounter Code



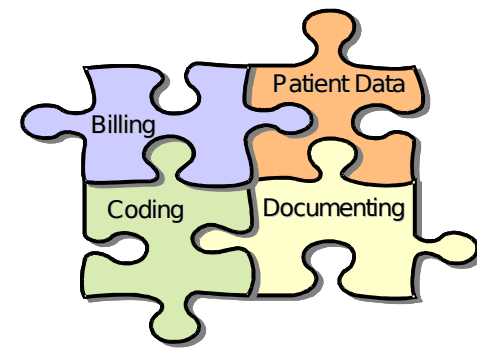
- Therapy or Prevention
- With or Without E/M or Medication Management Services
- Length of Time

Choosing an Encounter Code



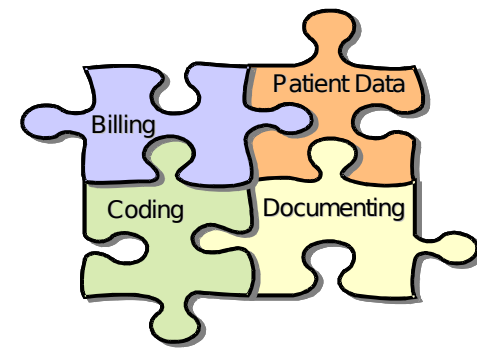
- Group or Individual
- Provider Type
 - Physician
 - Therapist

Social Work and Family Advocacy Services



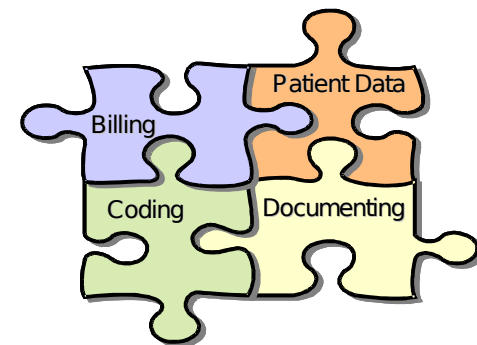
- Who can code:
 - Active duty
 - Defense Health Program Funded Civilians

Services coded by SW and FAS



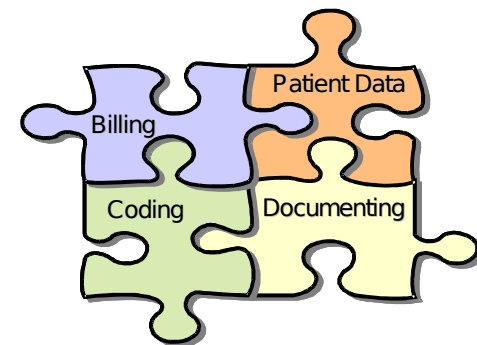
- Initial FAP assessment; no evidence/allegation
 - ICD-9: V71.9 Observation for Unspecified Suspected Condition
 - E/M: 99499
 - CPT: 90801 Diagnostic Interview

Continued SW and FAS



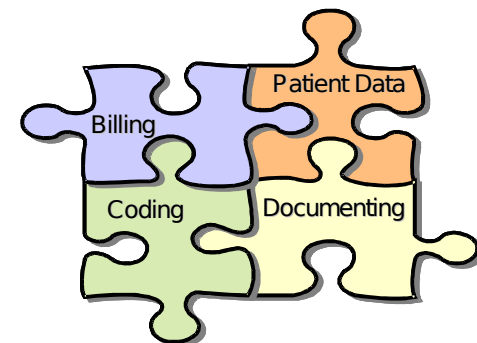
- Initial FAP assessment; evidence/allegation present; adult maltreatment
 - ICD-9: 995.80 Adult Maltreatment
 - E&M: 99499
 - CPT: 90801 Diagnostic Interview

Continued SW and FAS



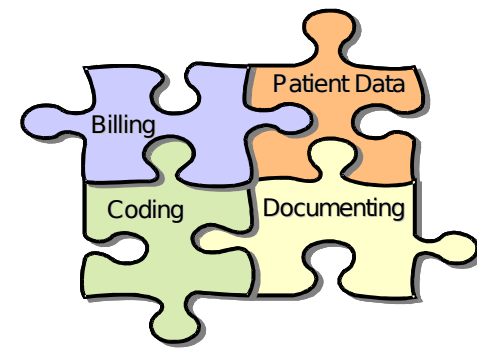
- Initial FAP Assessment; Evidence/Allegation Present; Child Maltreatment
 - ICD-9: 995.50 Child abuse
 - E/M: 99499
 - CPT: 90801 Diagnostic Interview

Continued SW and FAS



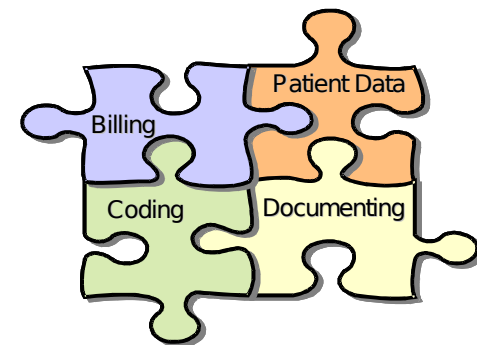
- Individual Follow-up for Maltreatment
 - ICD-9: 995.80 Adult Maltreatment or 995.50 Child Abuse and V61.10 Marital/Partner Problems
 - E/M: 99499
 - CPT: 90804 20-30 Minutes Therapy
90806 45-50 Minutes Therapy
90808 75 -80 Minutes Therapy

Continues SW and FAS



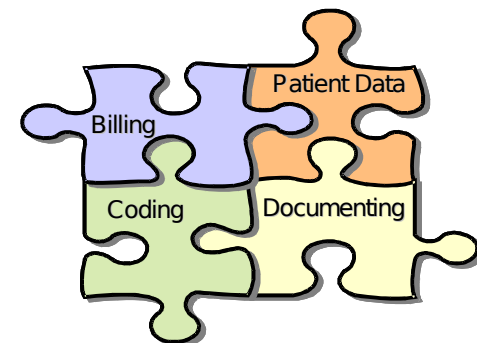
- Group Treatment
 - ICD-9: 995.80 Adult Maltreatment or 995.50 Child Abuse and V61.20 Parent Child Problem or V61.22 Perpetrator of Parent/ Child Abuse
 - E/M: 99499
 - CPT: 90853 Group Psychotherapy

Continued SW and FAS



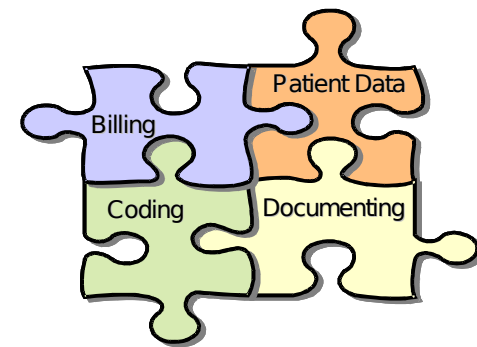
- Marital or Family Treatment
 - ICD-9: 995.80 Adult Maltreatment or 995.50 Child Abuse and V61.20 Parent/Child Problem or V61.22 Perpetrator of Parent/Child Abuse
 - E/M: 99499
 - CPT: 90847 Family Psychotherapy

Substance Abuse Program Services



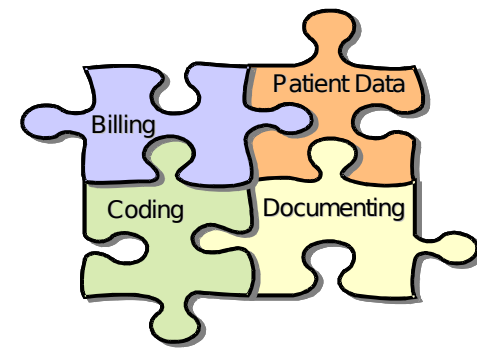
- Who Can Code
 - Active Duty
 - Licensed Chemical Dependency Counselors
 - Certified Alcohol Drug Abuse Counselors
 - Defense Health Program Funded Civilians

Substance Abuse Continued



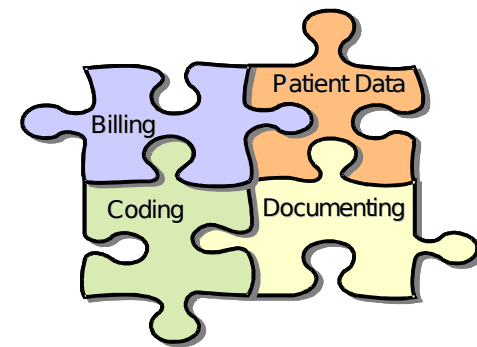
- HCPCS Level II Codes (examples)
 - Alcohol and Drug Assessment H0001
 - Behavioral Health Counseling/Therapy H0004 (per 15 minutes)
 - Alcohol and Drug Services Group by clinician H0005
 - Alcohol and Drug Services, Crisis Intervention H0007 (outpatient)
 - Contact your auditor for a complete list

Substance Abuse Continued



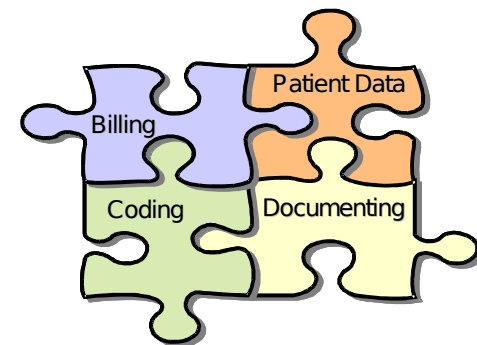
- Diagnosis Coding Rules
 - Substance Abuse Disorders
 - Never reported as dependence without specific documentation of dependence
 - LCDIC and CADAC
 - Can diagnose substance abuse problem, but the privileged provider must evaluate the patient for a diagnosis of dependence

Substance Abuse continued



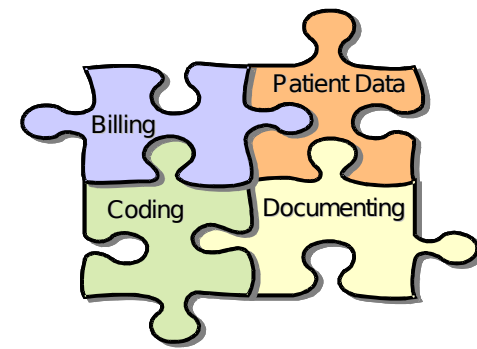
- Evaluation and Management
 - An Unlisted E&M Code
 - 99499 must be entered in ADM at the present time due to system limitations. This code has no effect on your encounter coding

Behavioral Health Optimization Program



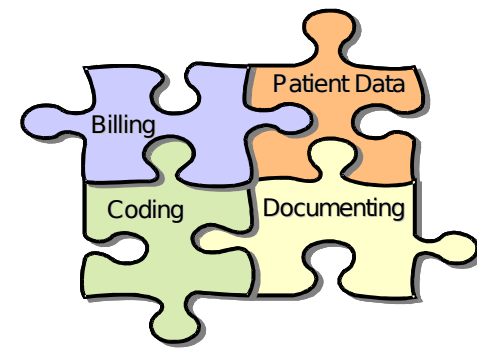
- Two Categories
 - Health and Behavioral Assessment and Intervention (96150-96155)
 - Used to Identify the
 - Psychological
 - Behavioral
 - Emotional
 - Cognitive
 - Social Factors
 - » That are affected by physical health problems
 - These are not mental health visits

BHOP Continued



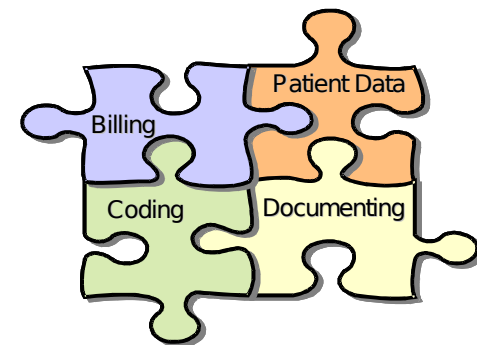
- Psychiatric Services
 - 90801 Initial Interview
 - 90804 Therapy 20-30 Minutes
 - 90806 Therapy 45-50 Minutes
 - 90808 Therapy 75-80 Minutes

BHOP Consultation



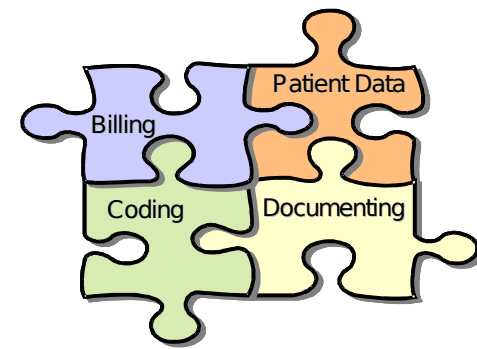
- Psychiatrist documents
 - The request from another provider
 - For an opinion or advice
 - Document the opinion you render and services ordered
 - Can initiate diagnostic or therapeutic services
 - Report findings back to the requesting provider

DSM-IV versus ICD-9 CM



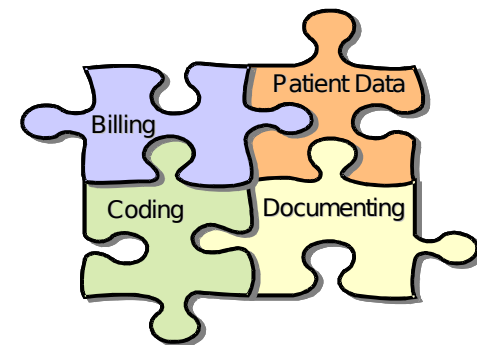
- DSM-IV
 - Identifies pertinent issues regarding each diagnosis
 - Comprehensive and unbiased information
 - Reflects the best available clinical and research literature
- ICD-9-CM
 - Does not include diagnostic criteria
 - Does not use multi-axial system
 - Basic health information
 - Medical in nature

The Purpose of DSM-IV



- Provide Clear Descriptions of Diagnostic Categories
- Enable Clinicians and Investigators to Diagnose
- Communicate, Study, and Treat People with Various Mental Disorders

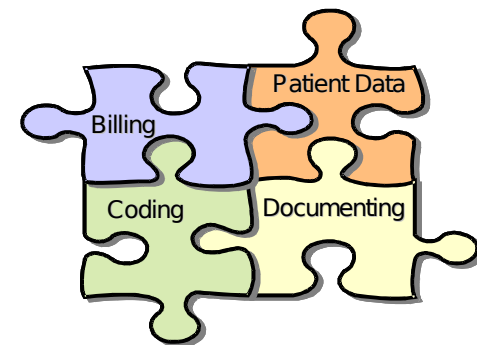
296.21



- The fifth digit on the code

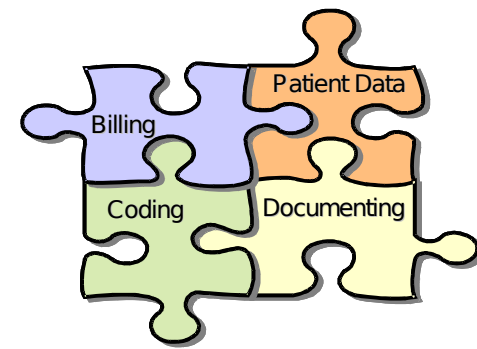


The 5th digit, what does that mean



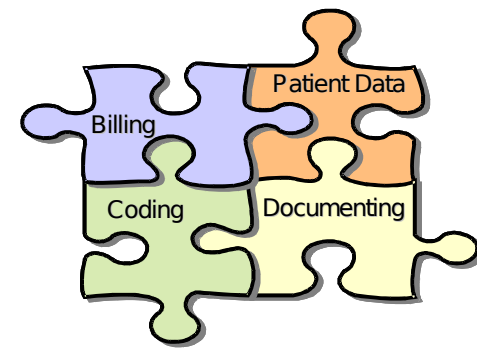
- Diagnosis Codes are Composed of Either 3, 4, or 5 Digits
 - 311 Depressive Disorder NOS (3 digits)
 - 315.1 Mathematics Disorder (4 digits)
 - 315.31 Expressive Language Disorder (5 digits)

Principal Diagnosis



- The reason for visit is the condition that is chiefly responsible for the ambulatory care medical services received during the visit
 - Main focus or attention for the visit
 - Multi-axial
 - Non-axial

Multi-axial and principal diagnosis

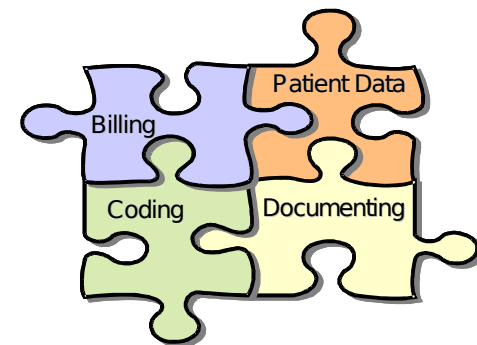


- Axis I
 - Clinical Disorders
 - Other Conditions
- Axis II
 - Personality Disorders
 - Mental Retardation
- Axis III
 - General Medical Con
- Axis IV
 - Psychosocial and Environ
- Axis V
 - Global Assess of funct



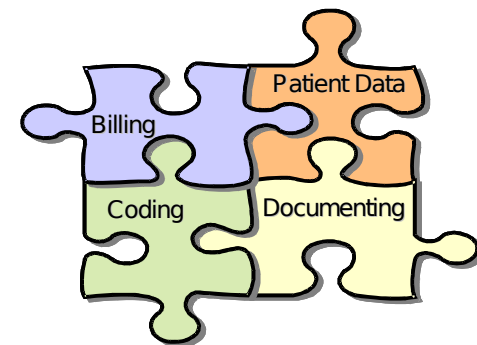
I said **AXIS** not
axle

Nonaxial format



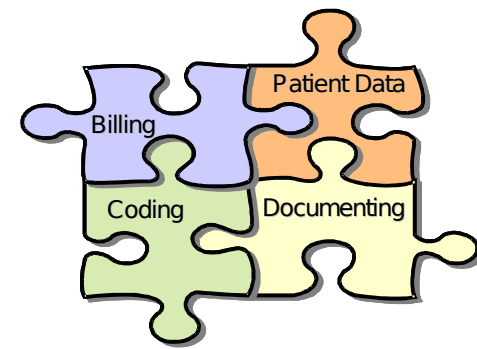
- Clinicians who do not wish to use the multiaxial format may simply list the appropriate diagnoses
- General rule of recording as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual
- The principal diagnosis or the reason for visit should be listed first

Modifiers



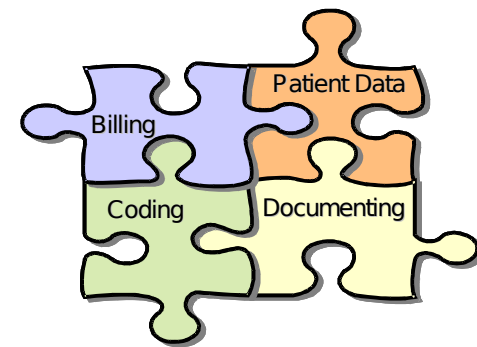
- AH Clinical Psychologist
- AJ Clinical Social Worker
- HF Substance Abuse Program
- HO Master's degree level
- HP Doctoral Level
- HQ Group Setting
- HR Family/Couple with client present
- HS Family/couple w/o client present
- HE Mental Health

Modifiers Continued



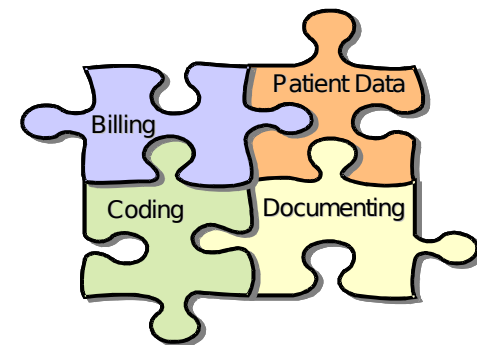
- Appended to CPT & HCPCS Codes
 - For a full list contact your auditor/coder

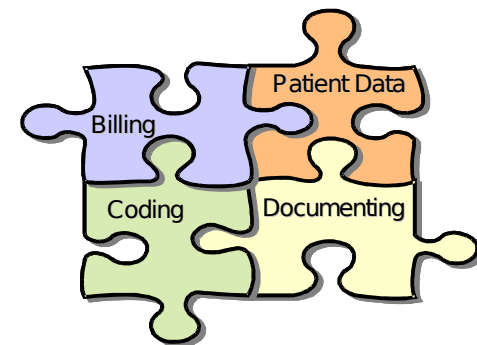
Wrap it up



- Define Who Can Code
- Confidentiality Concerns and Documentation
- Define What Services Can Be Coded
- Define Difference Between ICD-9 and DSM-IV
- Discuss Modifiers

Questions?



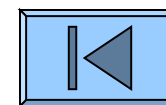


External Cause of Injuries and E - Codes

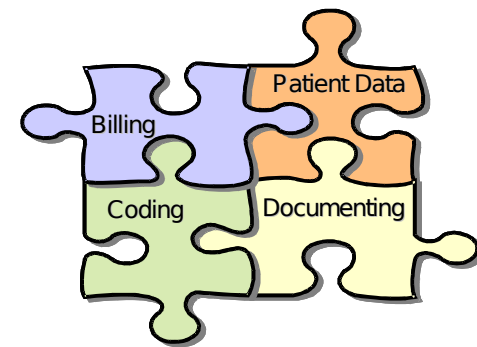
LaNiece Sharpling, CCS

Wednesday, 18 May 2005

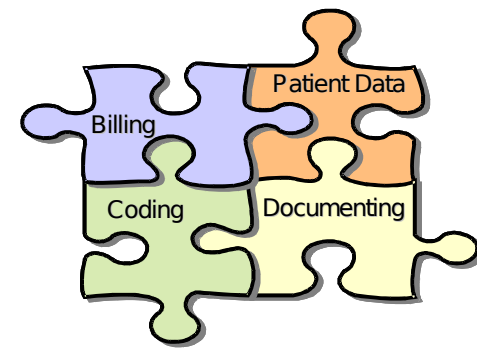
Track 1, UBU



Objectives

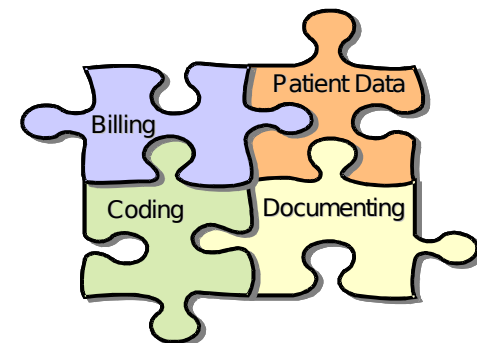


- Know what E-Codes are
- Understand why they are used
- Determine how they are used
- Know when they are used



General E- Code Guidelines

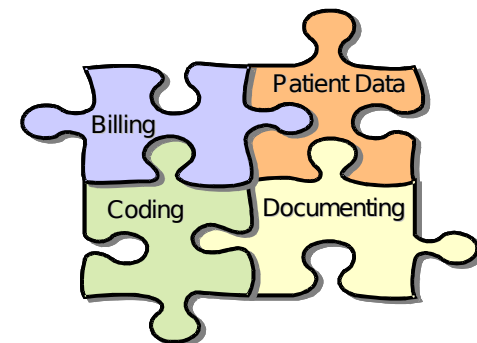
What Are E-Codes?



Alpha-numeric codes used to supplement ICD-9-CM codes when there is an injury reported

An E-Code can never be the principal (1st) diagnosis

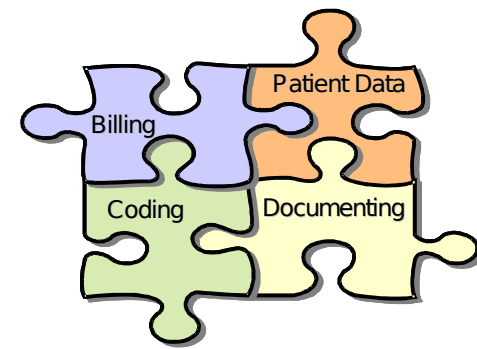
How are E-Codes Used?



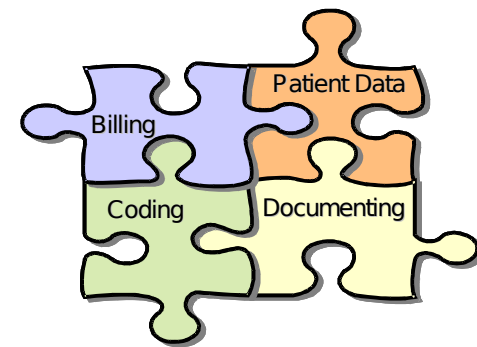
An E code should be used with any diagnosis code that indicates:

- An accident resulting in an injury
- Poisoning
- An adverse effect due to an external cause
- Late effect from a previous injury

Why Are E-Codes Used?

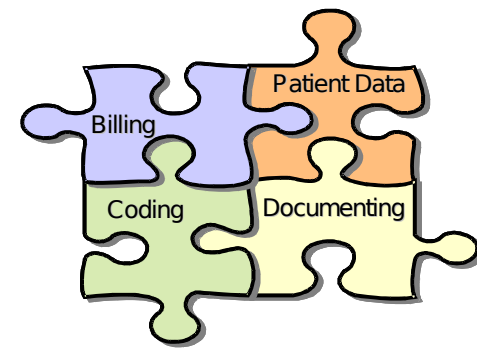


- Provide data for injury research and evaluation of injury prevention strategies. Capturing:
 - how the injury happened (cause)
 - the intent (unintentional or accidental; or intentional, such as suicide or assault)
 - the place where the event occurred (E849.x)



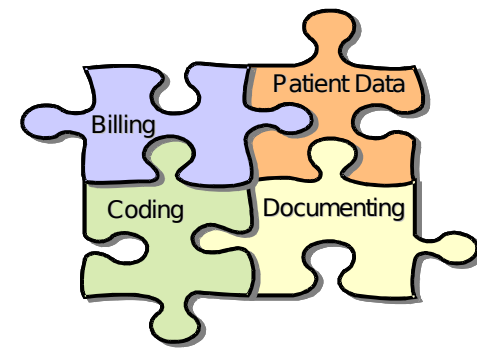
Late Effect of External Cause Guideline

Late Effect of External Cause Guideline



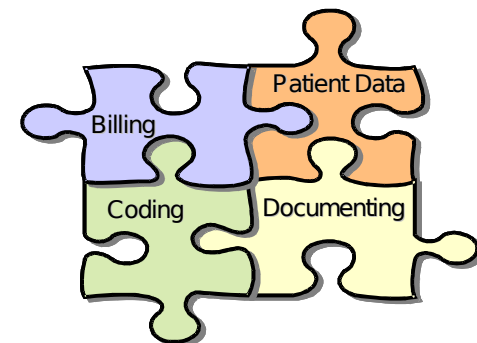
A late effect E-code (E929, E959, E969, E977, E989, or E999.1) should be used with any report of a late effect resulting from a previous injury or poisoning (905-909).

Late Effect of External Cause Guideline



- There is no late effect E-code for adverse effects of drugs, misadventures and surgical complications.
- Do not use a late effect code with a related **current** injury code
- No time limit on when a late effect code can be used
 - Condition/nature of the late effect sequence first
 - Late effect E-code sequence second

Example of Late Effect Coding



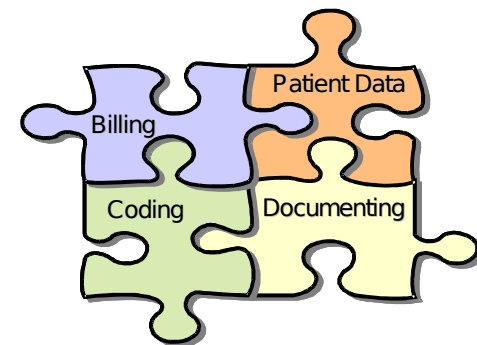
Pt has painful scar on palm.

The accident was caused by a campfire 2 years ago, which resulted in a 3rd degree burn to the palm.

- 709.2 Scar condition and fibrosis of skin
- 906.6 Late effect of a burn of wrist/hand
- E929.4 Late effect of accident caused by fire

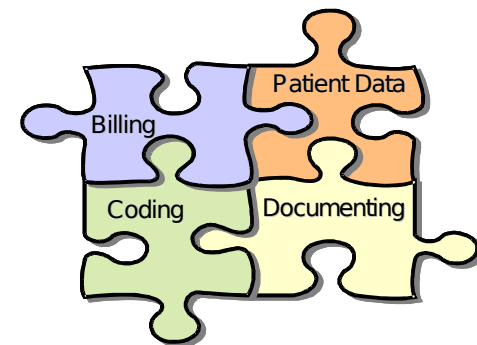


When the Diagnosis Code is in the Range of:



- 800-999
- 692.71, 692.76, 692.77
- V71.3-V71.6, or V71.8x
- Then at least one E code **must** be entered on the ADM record the first time the patient is seen for the condition

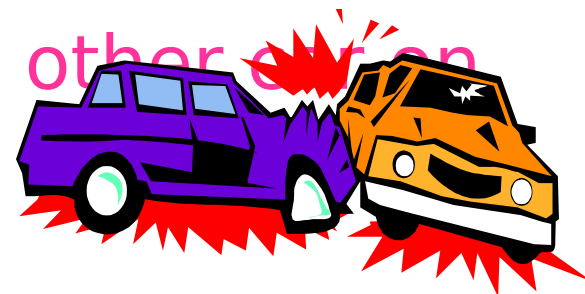
Coding Example of an Accident

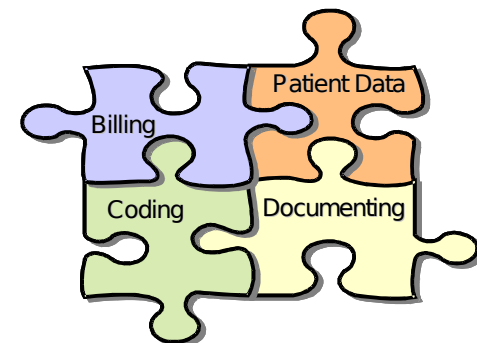


Pt involved in car accident with another car on Highway 101 ... Pt was the driver

Injury Diagnosis is a neck sprain

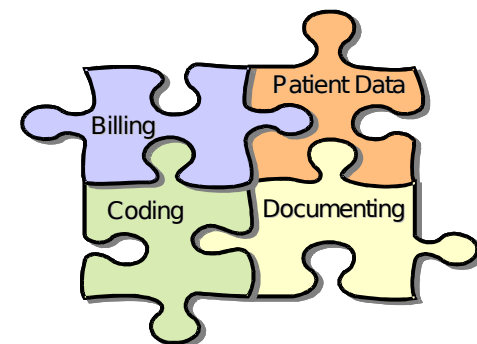
- 847.0 *Sprain neck*
- E813.0 MVA Collision with other car on the Highway-driver
- E849.5 Street/Highway



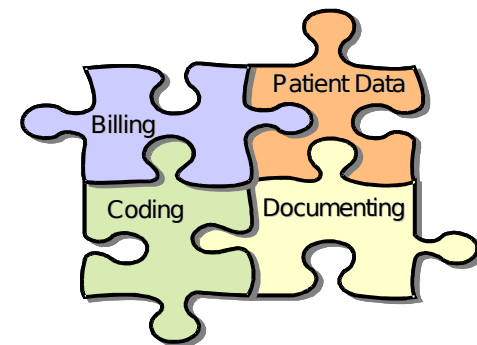


Misadventures and Complications of Care Guideline

Misadventures and Complications of Care Guideline

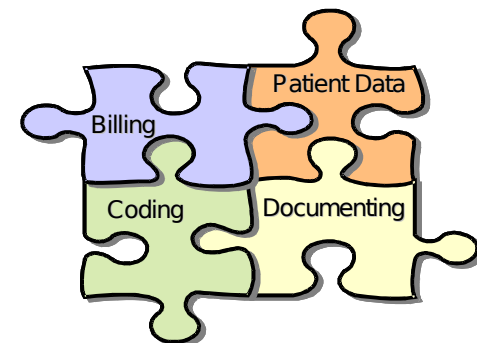


- E870-E876 are utilized ONLY if the misadventure is stated by the physician
- E878-E879 are utilized ONLY if the physician attributes an abnormal reaction/complication post procedure, not occurring during the procedure as the cause of the reaction

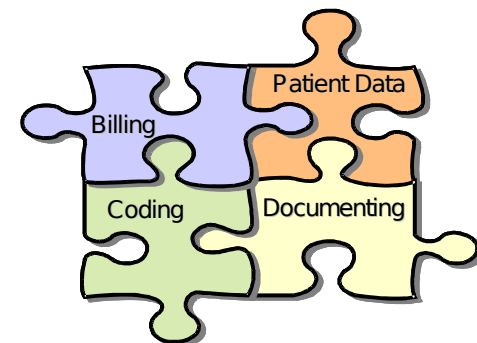


Terrorism Guidelines

Terrorism Guidelines

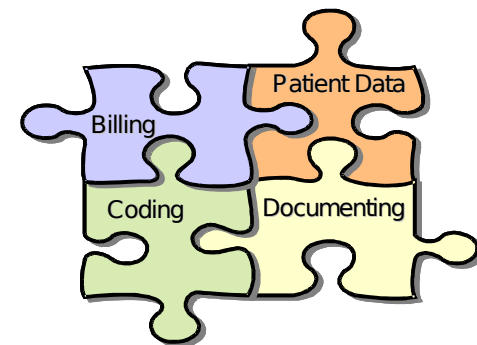


- When the cause of an injury is identified by the Federal Government as terrorism
- Only list the E Code from category E979.x, Terrorism
- Additional E Codes from the assault categories are NOT assigned
- Do NOT assign E979.x code if the injury is “Suspected” to be a result of Terrorism



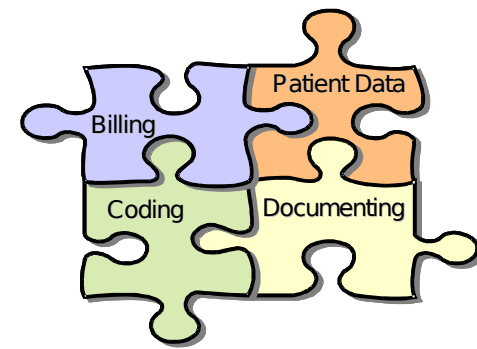
Place of Occurrence Guideline

Place of Occurrence Guideline



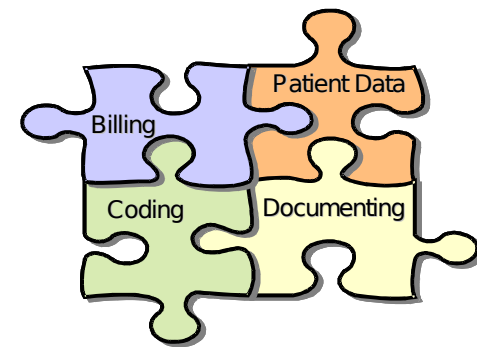
- From category **E849.x**
 - Describes the place where the event took place
- **Not to be confused with what the pt was doing**

Use the Full Range of E Codes to Completely Describe:

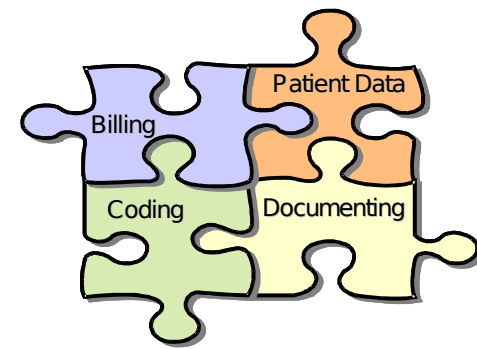


- the cause,
- the intent,
- and the place of occurrence

If applicable, for all injuries,
poisoning, and adverse effects of
drugs.

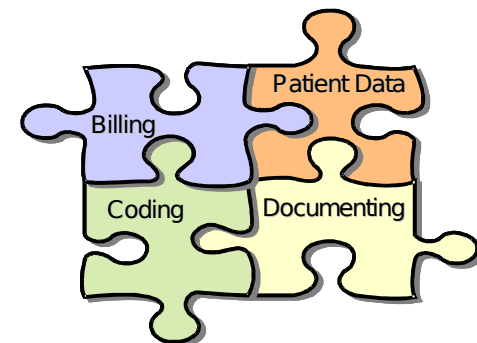


- Assign as many E codes as necessary to fully explain each injury cause.
- All ICD-9-CM codes describing the reason for treatment must precede the E codes.
- If only one E code can be reported in ADM, assign the E code most related to the primary diagnosis or injury.

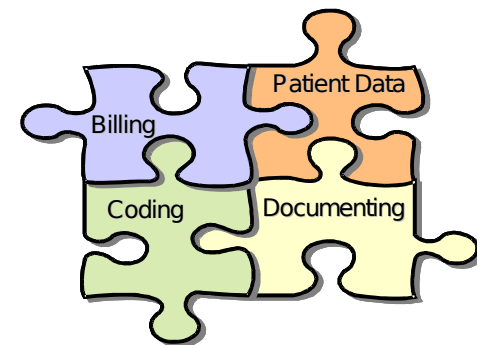


Due to limited number of reporting fields (currently only 4 listed diagnoses) in the Standard Data Record (SADR), the E codes **should be** the codes listed after the more critical injuries are listed.

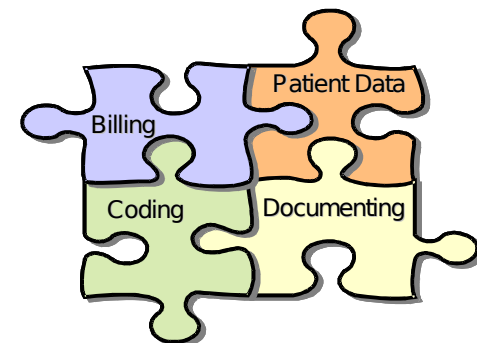
Common E Codes for Chiropractic, Emergency Room, and Physical Therapy



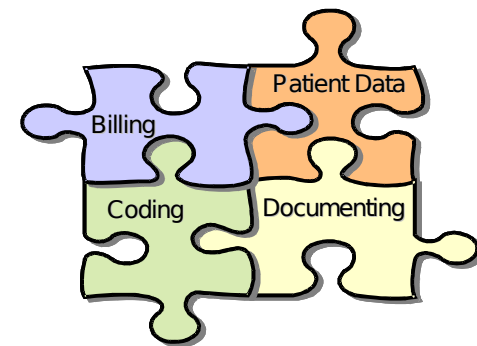
- E819.9 Unspecified motor vehicle accident/unspecified person*
- E826.6 Pedal Cycle accident*
- E831.9 Accident to watercraft causing injury
- E843.9 Fall in, on, or from aircraft
- E880.1 Fall on or from sidewalk/curb
- E880.9 Fall from stairs or steps
- E882.9 Fall from or out of bldg.
- E883.9 Fall into hole or other opening in surface



- E884.9 Fall from one level to another*
- E885.1 Fall from roller skates
- E885.2 Fall from skateboard
- E885.3 Fall from skis
- E885.4 Fall from snowboard
- E885.9 Fall from slipping, tripping, or stumbling
- E886.0 Fall in sports from collision, shoving, or pushing by other person
- E888.0 Fall resulting in striking against sharp object
- E888.9 Unspecified fall

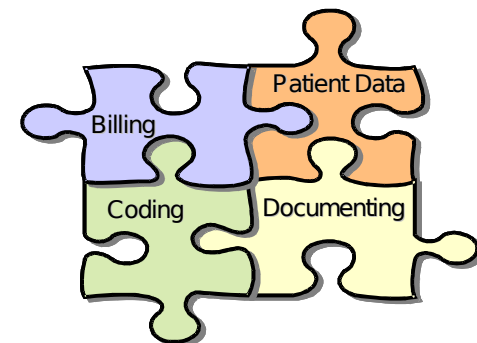


- E917.0 Striking against/struck acc. by object or other person in sports
- E917.1 Caused by a crowd, by collective fear or panic
- E917.3 Striking against furniture without subsequent fall
- E917.4 Striking against stationary object (bathtub, fence, light post)
- E917.5 Striking against object in sports (knocked down while boxing)
- E917.8 Striking against furniture with subsequent fall
- E917.9 Other striking against unspecified



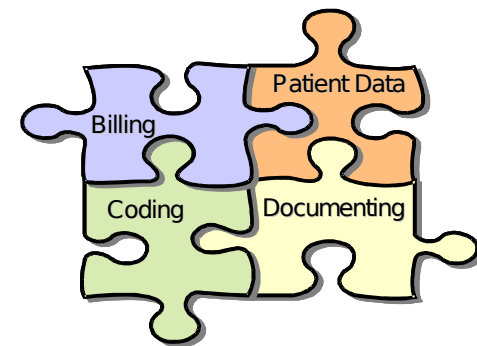
- E927 Overexertion and strenuous movements
- E929.0 Late effects of motor vehicle accident
- E929.1 Late effects of other transport accident
- E929.3 Late effects of accidental fall
- E929.8 Late effects of other accidents
- E929.9 Late effects of unspecified accident
- E960.0 Injury purposely inflicted by other person; a fight, brawl
- E985.3 Injury by military firearms
- E990.9 Injury due to war, other and unspecified source

Location E Codes

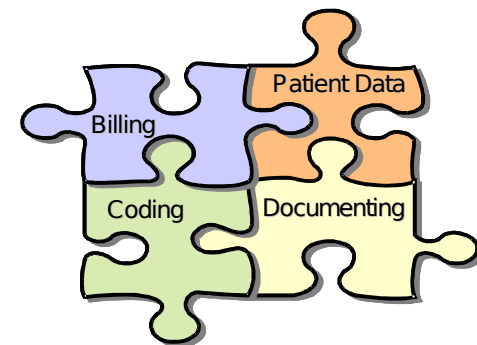


- E849.0 Accident occurred at home
- E849.1 Accident occurred on a farm
- E849.2 Mine and quarry (gravel pit, sand pit)
- E849.3 Industrial place and premises
- E849.4 Place for recreation and sport
- E849.5 Street and highway
- E849.6 Public building
- E849.7 Residential institution
- E849.8 Other specified places
- E849.9 Unspecified place
 - * Higher levels of specificity located in ICD-9 coding book

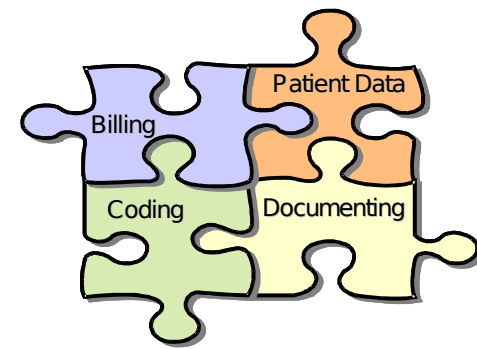
Summary



- You now know what E-Codes are:
E-Codes are alpha-numeric codes
- You now understand why they are used:
E-Codes assist in the gathering of data for statistical analysis on injuries, and their prevention

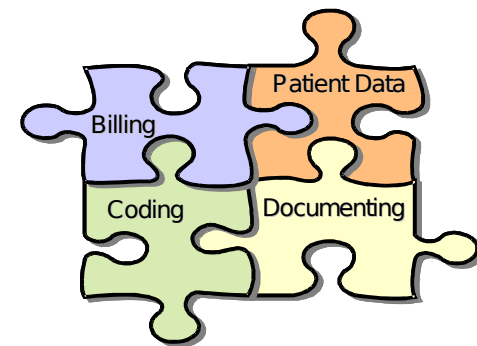


- You have determined how they are used:
Used to describe the how and the where an accident, injury, or poisoning has occurred
- You now know when they are used:
When we capture data on:
 - how the injury happened (cause)
 - the intent (unintentional or accidental; or intentional, such as suicide or assault)
 - the place where the event occurred (E849.x)

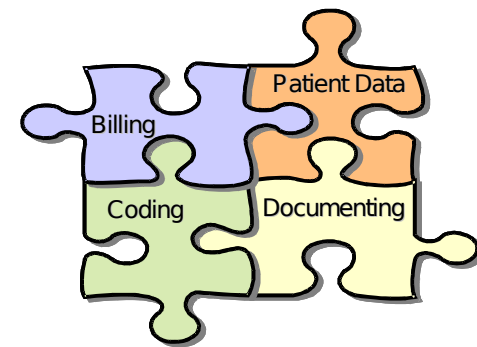


- Questions?

References



- UBU Coding Guidelines Version 1.0
January 2005
- ICD 9-CM Official Guidelines for Coding and Reporting April 1, 2005
- ICD 9-CM Coding for Physicians-Vol. 1, 2005



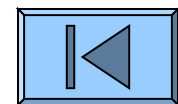
Coding and Workload Integration Committee

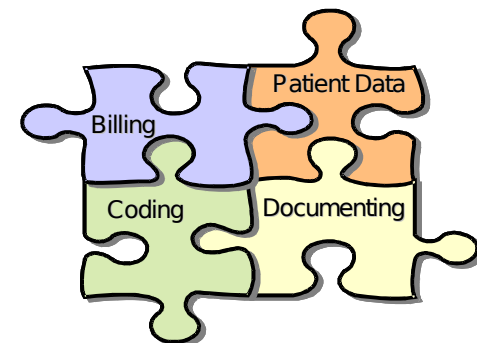
Pat Wesley, MMIG Chairman

Lt Col Jeanne Yoder, UBO Program Manager

Lt Col Steve Toney, UBU Chairman

18 May 2005 Track 1 and 2

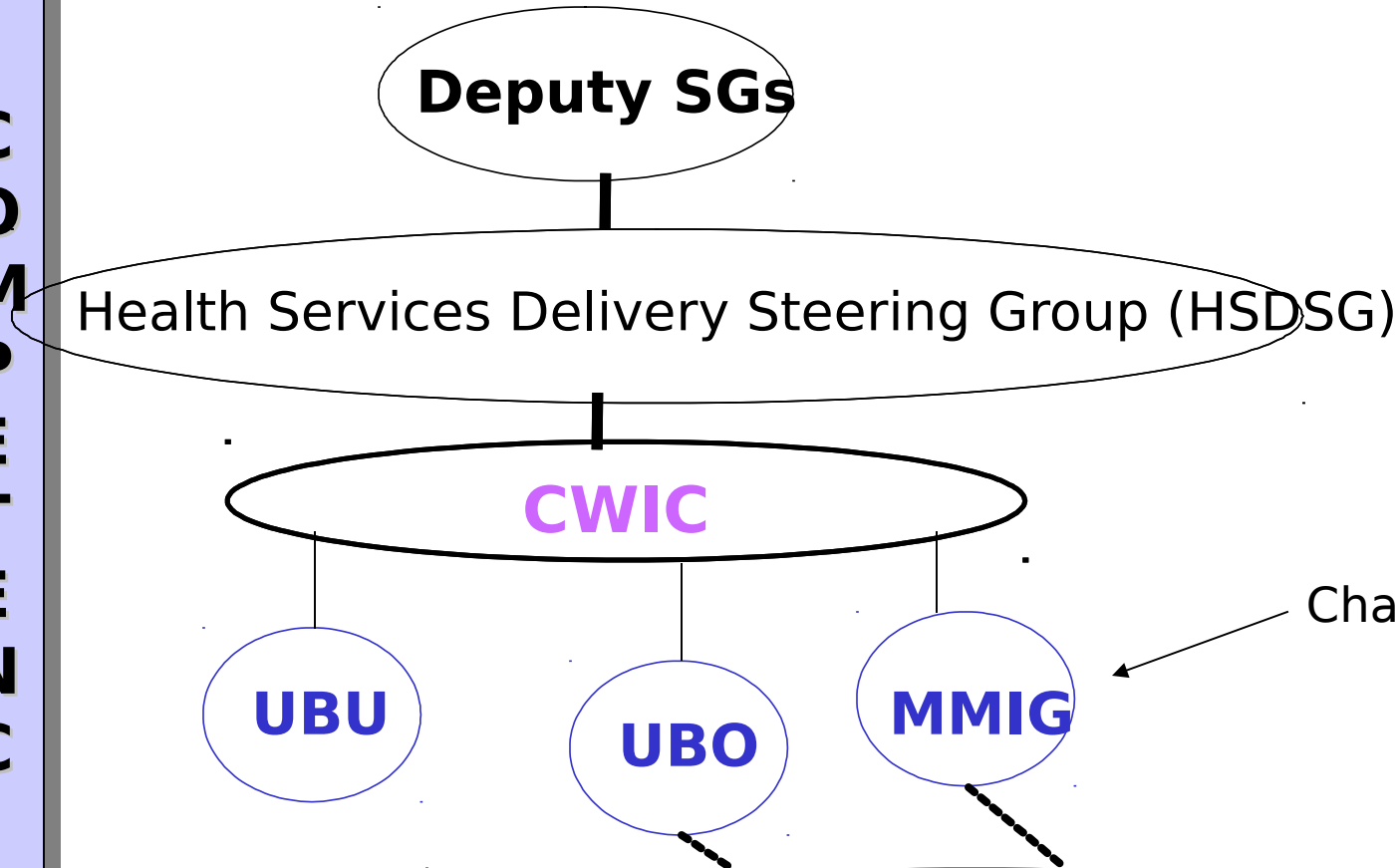
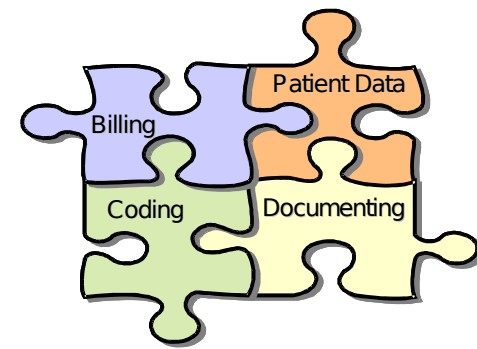




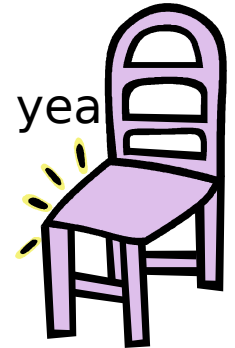
Overview

- Defense Surgeon General (DSG) origin
- UBU, UBO, & MMIG Workgroup Definition
- Intent of the CWIC Charter
- CWIC Problem / Issue List
- Problem Identification / Issue Resolution / Staffing Procedures

Coding & Workload Integration Committee (CWIC)



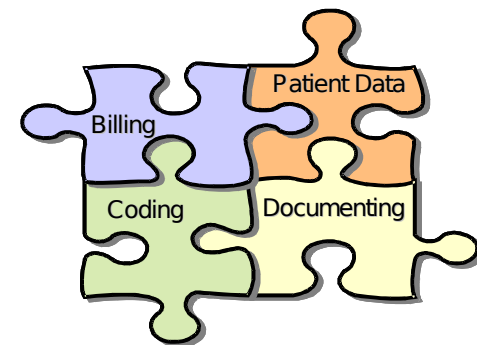
Chair this year



Resource Management Steering Committee
 Unified Biostatistical Utility/Uniform
 Business Office Conference 2005

UBU = Unified Biostatistical Utility

**note: translation on future
slide, you will not be quizzed
on this slide**

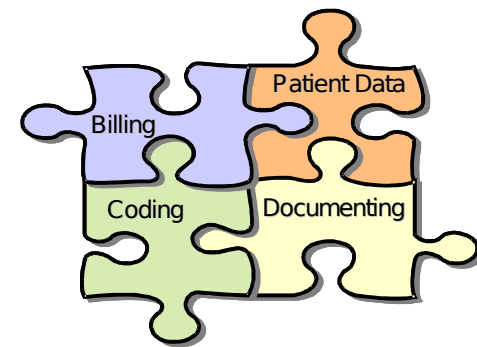


Purpose

- Develop recommended functional requirements for biostatistical data within DoD healthcare systems.
- Develop recommended **standardized biostatistical data elements**, business processes, **diagnostic and procedure codes**, and algorithms required for detailed analysis across the MHS in a manner consistent with other federal agencies and civilian best practices.
- Serve as the functional proponent for **professional and institutional coding practices for the MHS**.
- Serve as the functional proponent of the DoD Healthcare Glossary, aligning business processes and data definitions across the MHS.

<http://www.tricare.osd.mil/org/pae/ubu/default.htm>

UBO = Uniform Business Office



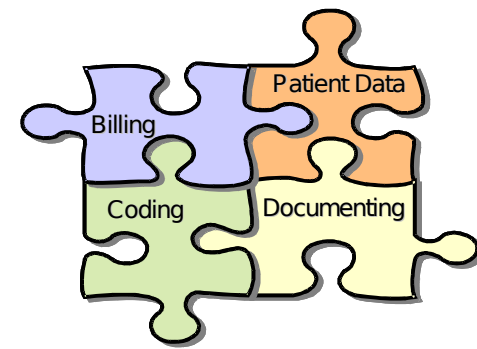
**note: translation on future slide,
you will not be quizzed on this slide**

Purpose

- Serves as the policy & advisory body for the development & recommendation of the strategic direction for the RMSC pertaining to:
 - Third Party Collection Program (TPCP)
 - Medical Affirmative Claims (MAC) facility support
 - Medical Service Accounts (MSA)
- Identifies, reviews, validates & prioritizes functional changes/improvements for the program and systems supporting UBO operations (CHCS, ADM, TPOCS)

MMIG = MEPRS Management Improvement Group

**note: translation on future slide,
you will not be quizzed on this**

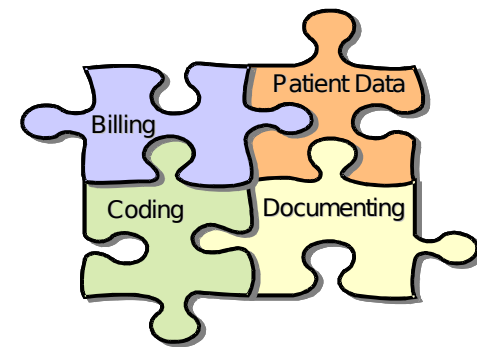


Purpose:

- Provide functional oversight of the DoD MEPRS Program
- Responsible for the development, implementation and management of MEPRS policies, procedures and business practices,
- Integrate the collection, processing and reporting of **standard** workload, financial, and labor data in the Expense Assignment System (EAS)
- Ensure MHS business practice standardization and procedural compliance related to the preparation, validation, audit, submission and reporting of MEPRS data

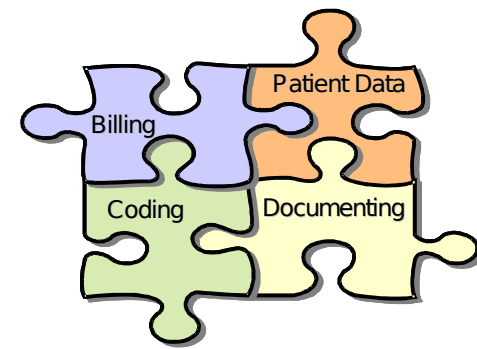
CWIC Objectives

**note: translation on future slide,
you will not be quizzed on this
slide**



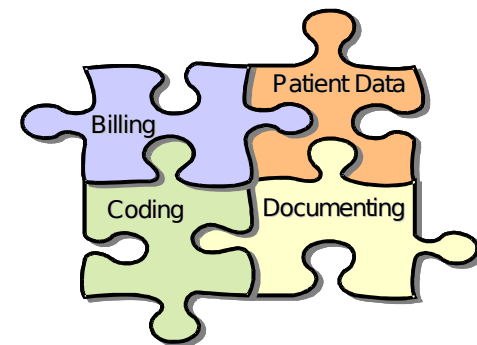
- Coordinate the activities of the UBU, UBO, and MMIG.
- Coordinate the automation requirements with the Requirements Management Section of Information Management (TMA).
- Coordinate coding and format standards with the Data Standards Configuration Management Board and the Steering Committee for the Standardization of Codes, Weights and Algorithms.
- Coordinate with the Data Quality Management Control Program

Membership



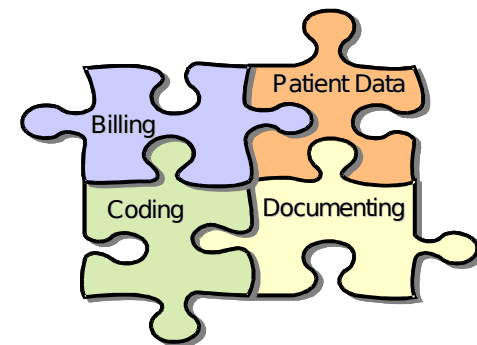
- Chairs of UBU, MMIG, and UBO (voting)
- Information Management representatives
 - Requirements Management (Manage the Business)
 - Steering Committee for the Standardization of Codes, Weights, and Algorithms
 - Data Standards Configuration Board

Translation



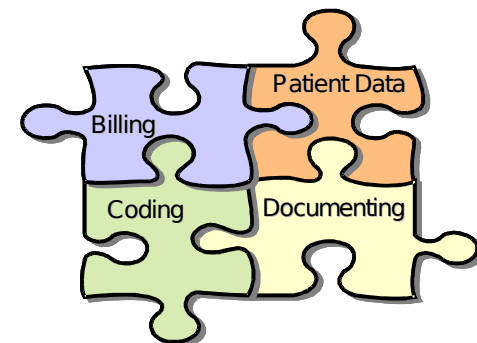
- CWIC tries to keep as many data users happy as possible – but we can't please everyone
- MMIG, UBO and UBU all participate in the other's meetings
- There are a lot of issues, that cross committee lines

Translation - MMIG



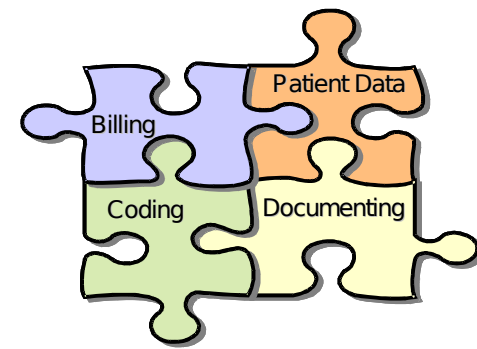
- Oversight committee for Medical Expense and Performance Reporting System (MEPRS)
- A chart of accounts, unique to the Military Health System (MHS).
- Collects cost and time in “MEPRS” cost centers. Sort of like “Revenue Codes” in the civilian sector.
- Four characters, the first, second and third are alpha characters. The fourth is alphanumeric.

Translation - MMIG



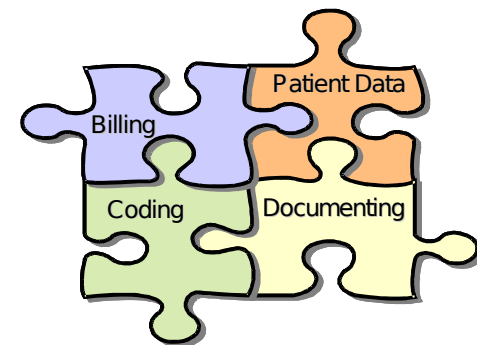
- Uses both MEPRS and CPT/HCPCS codes to collect workload
- A = inpatient (both institutional and professional)
- B = outpatient (both institutional and professional)
- C = dental
- D = ancillary (lab, rad, pharm, EKG...)
- E = administrative
- F = immunizations, hearing conservation, assistance to others...
- G = mobility/deployment

Bottom Line - MMIG



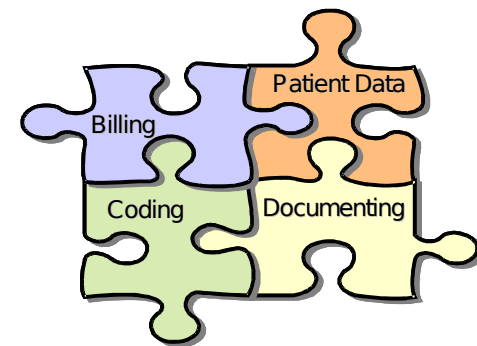
- Collects data used by the MHS to make decisions
 - MEPRS
 - Time
 - Numbers of procedures

Translation - UBU



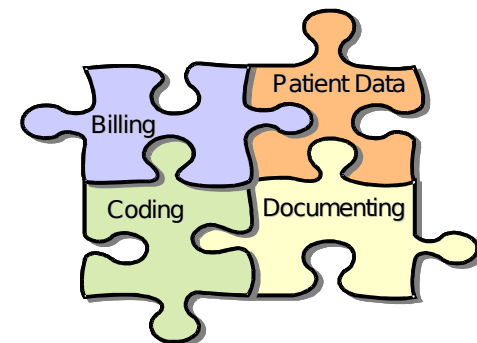
- Collects data related to healthcare encounters, both inpatient and outpatient

Bottom Line - UBU



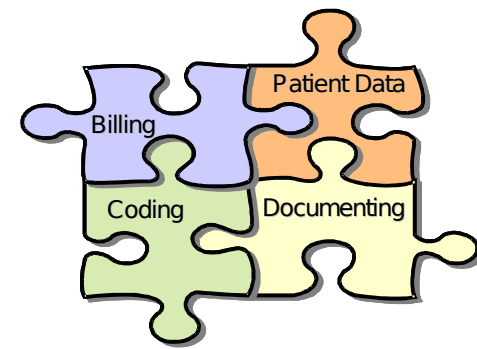
- UBU direct data collection
 - International Classification of Diseases (diagnoses, external causes of injury)
 - Current Procedural Terminology (CPT) (professional services such as office visits, surgeries, lab tests, radiology studies)
 - Healthcare Common Procedure Coding System (non-physician services and supplies)
 - PATCAT - patient categories
 - CHCS Provider Specialty Code
 - DMIS ID
 - STANAG Codes
 - Provider Type Code (CMAC category)

Translation - UBO



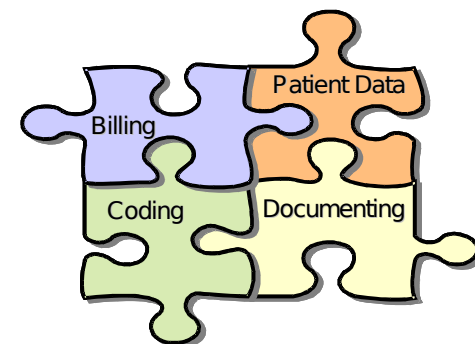
- Cost Recovery
 - Medical Affirmative Claims (Third Party Liability)
 - Medical Service Accounts
 - First Pay - DoD teachers, cosmetic surgery, civilian emergencies
 - Other federal organizations - Coast Guard, DVA
 - Third Party (beneficiaries with other health insurance)

Bottom Line - UBO



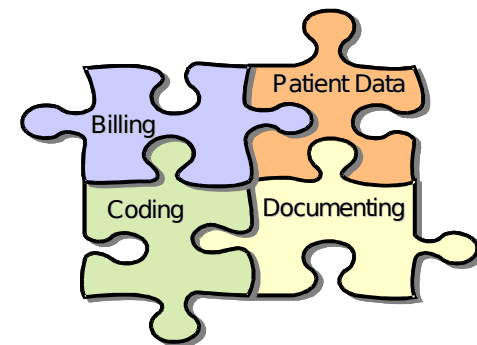
- UBO is mostly a data user
- UBO collects some insurance related information
 - Other health insurance information (DD Form 2569)
 - National Provider Identifier, type 2
 - HIPAA Provider Taxonomy
 - Injury log

Sample Issues



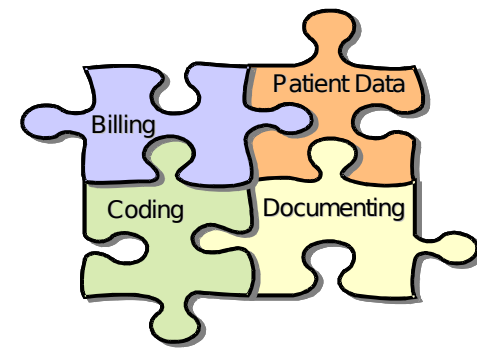
ISSUE	
1. Ranges of RVUs vs. Point Estimates	UBU
2. Sensitivity Analysis	HPA&E
3. MEPRS Accounting	UBU
4. Service Financial Accounting	MMIG
5. External Resource Sharing	MMIG
6. VA Sharing	MMIG
7. Non-Claims Payments	HPA&E
8. ASC Rates A/F	UBO
9. DHP vs. Line Funding	MMIG
10. Facility Charges	UBU
11. GWOT Charges	MMIG
12. Absolute Threshold	UBU
13. TELCONS	UBU
14. Pharmacy Expenses in Direct Expenses Unified Biostatistical Utility/Uniform	MMIG
15. Place of Service Business Office Conference 2005	UBU

VA Sharing



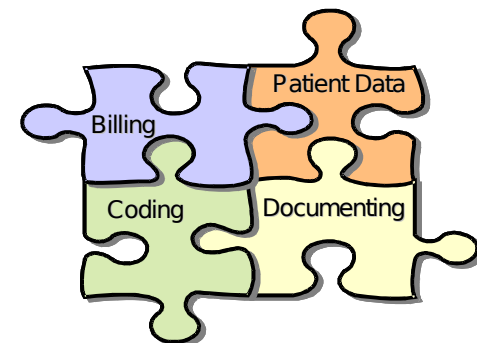
- Issues
 - MMIG - Barter
 - UBU - Splitting an encounter
 - Reflects the MTF institutional only (e.g., VA doctor sees a patient in our MTF)
 - Reflect the MTF provider only (e.g., our provider sees patients at the VA facility)
 - UBO - Billing, how to bill for just the institutional or partial institutional if there was bartering
 - HPA&E - Prospective Payment

Telephone Consults



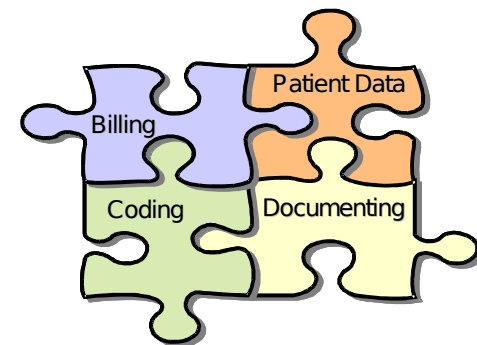
- MMIG – count goes to EAS; non-count doesn't
- UBU – in the civilian sector, doctor to doctor coordination can be coded with a t-con; but not defined that way in by UBU
- UBO – most insurance plans don't cover
- HPA&E – Right care at the right time with the right resources; need to motivate using t-cons instead of making the patients come to the MTF

Sample Issues



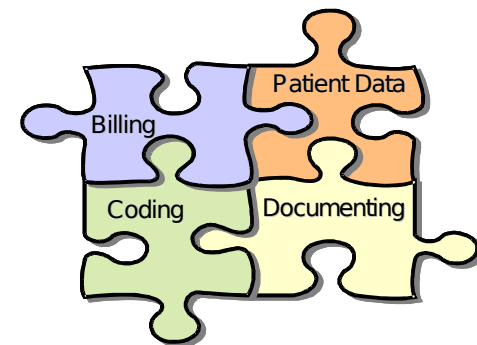
16. Generic Provider Codes	UBU
17. Valuation of E&M Codes	UBU
18. SAS Queries	MMIG
19. Other Ancillaries	MMIG
20. MTF “unit of analysis”	UBU
21. Excessive Number of Services in HCSRs	HPA&E
22. GME Admin Expenses	MMIG
23. Depreciation/Free Receipts (Combine with #3 for resolution)	MMIG
24. Corpsman Workload	UBU
25. HSSC-Like Functions in MTFs	HPA&E
26. Peer Groups	HPA&E
27. Total vs. Work RVUs	HPA&E
28. Displaying Government Paid in the Valuation Analysis	HPA&E

Corpsman Workload



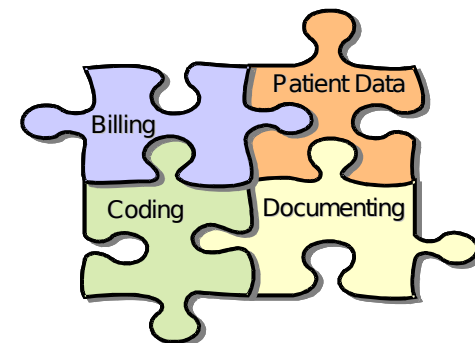
- MMIG – workload, between technician and privileged provider; non-count
- UBU – not privileged provider, but doing traditional privileged provider tasks (e.g., treating new medical problems)
- UBO – need HIPAA taxonomy for insurers to understand level of care
- HPA&E – Prospective Payment

Total Relative Value Units and Work Relative Value Units



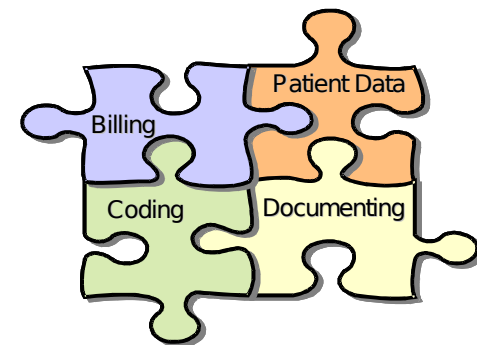
- MMIG – EAS IV RVUs – work and institutional
- UBU – using modifiers changes amount of RVUs
- UBO – different rates for just the institutional component of a procedure (e.g., VA doctor do procedure in our MTF), a colonoscopy done in our OR or a colonoscopy done in the doctor's office
- HPA&E – modifiers stay at the MTF server, do not transmit to M2

Sample Issues



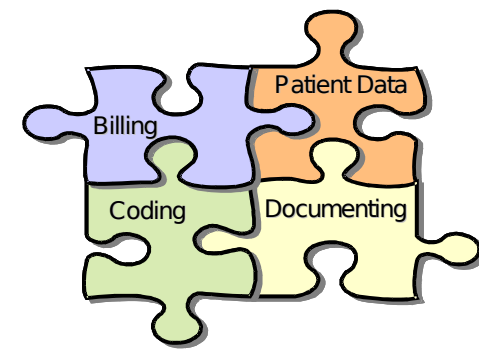
29. Appropriate Burdening in Government Paid	HPA&E
30. MTF Production Cost Burdening	HPA&E
31. Non-Military Beneficiaries	HPA&E
32. DHP versus OMB Costs	HPA&E
33. Internal Resource Sharing Expenses	HPA&E
34. Industry Based Workload Adjustment (IBWA)	UBU
35. ER	UBU
36. IMPACT/Reduction Factors	HPA&E
37. NMOP versus Retail Pharmacy Rates	UBO
38. Patient Movement (Transportation)	MMIG
39. MEPRS-F Account Valuation	MMIG
40. Radiology Code Modifiers	UBO
41. Inclusion of OCONUS MTFs	HPA&E
42. MEPRS-D Account Valuation	MMIG
43. APV Claims Costs	UBO
44. RN Workload	HPA&E

Industry Based Workload Alignment



- MMIG – MEPRS vs. civilian revenue codes
- UBU – Military unique data needs
- UBO – Charge Master Based Billing
- HPA&E – Want to compare to HCSRs and the civilian sector; looks at ALL professional services, not just in “B” MEPRS

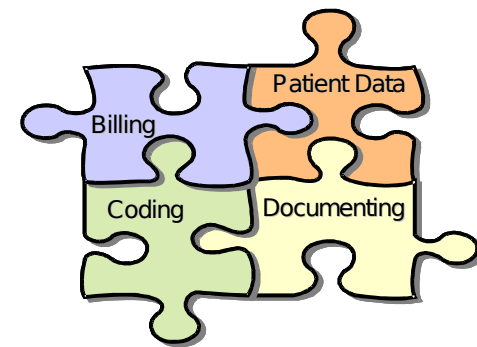
Problem Identification / Issue Resolution / Staffing Procedures



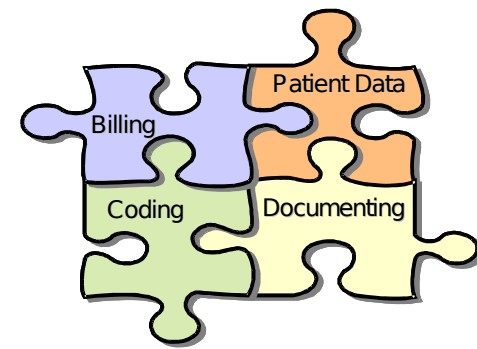
**note: translation on future
slide, you will not be quizzed on
this slide**

- Portals: vetted through chair or DSG request for staffing
- Reporting: business practice & rules, information management requirements, functional convergence & IM integration
- Resolution: consensus or DSG decision

Objectives



- Understand how the MMIG uses data
- Understand how the UBU uses data
- Understand how the UBO uses data
- Understand how data collection/use conflicts are resolved



- Questions?